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Nicholas Sorensen, Kevin and Pamela Sorenson v. Barbuto : Brief of Appellant

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

NICHOLAS SORENSEN, KEVIN AND PAMELA SORENSEN, limited guardians and conservators of Nicholas Sorensen, Plaintiffs and Appellant, vs. JOHN P. BARBUTO, individually, JOHN P. BARBUTO, M.D., P.C., dba NEUROLOGY IN FOCUS, Defendants and Appellees.	Case No. 20050501

APPEAL FROM A JUDGMENT AND ORDER
HONORABLE TYRONE E. MEDLEY
THIRD JUDICIAL DISTRICT COURT IN AND FOR
SALT LAKE COUNTY, STATE OF UTAH

BRIEF OF APPELLANTS

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LIST OF PARTIES TO THE PROCEEDINGS

All parties to the proceedings below are identified in the caption on appeal.

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JURISDICTION

Jurisdiction is proper in this Court pursuant to Utah Code Ann. § 78-2-2(3)(j), as amended.

ISSUES PRESENTED FOR REVIEW

The following issues are presented to this Court for review:

ISSUE NO. 1: Did the district court err in ruling that appellants' complaint failed to state a claim for breach of implied contractual duties? This issue was addressed below in connection with the defendants' motion to dismiss. (R. 16-29, 33-85, 119-135).

STANDARD OF APPELLATE REVIEW: A trial court's ruling on a motion to dismiss is reviewed for correctness by the Court. *Buckner v. Kennard*, 2004 UT 78, ¶ 9, 99 P.3d 842.

ISSUE NO. 2: Did the district court err in ruling that appellants' complaint failed to state a tort cause of action against the defendants (including breach of confidentiality, breach of fiduciary duty, invasion of privacy, intentional infliction of emotional distress, and negligence)? This issue was addressed below in connection with the defendants' motion to dismiss. (R. 16-29, 33-85, 119-135).

STANDARD OF APPELLATE REVIEW: A trial court's ruling on a motion to dismiss is reviewed for correctness by the Court. *Buckner v. Kennard*, 2004 UT 78, ¶ 9, 99 P.3d 842.

ISSUE NO. 3: Did the district court err in ruling that the complaint failed to state a cause of action because damages had not been sufficiently alleged? This issue was

addressed below in connection with defendants' motion to dismiss. (R. 16-29, 33-85, 119-135).

STANDARD OF APPELLATE REVIEW: A trial court's dismissal for failure to state a claim is reviewed de novo by the Court. A trial court's ruling on a motion to dismiss is reviewed for correctness by the Court. *Buckner v. Kennard*, 2004 UT 78, ¶ 9, 99 P.3d 842.

DETERMINATIVE STATUTES AND RULES

Utah Rule of Evidence 506(b):

> *General rule of privilege.* If the information is communicated in confidence and for the purpose of diagnosing or treating the patient, a patient has a privilege, during the patient's life, to refuse to disclose and to prevent any other person from disclosing (1) diagnoses made, treatment provided, or advice given, by a physician or mental health therapist, (2) information obtained by examination of the patient, and (3) information transmitted among a patient, a physician or mental health therapist, and persons who are participating in the diagnosis or treatment under the direction of the physician or mental health therapist, including guardians or members of the patient's family who are present to further the interest of the patient because they are reasonably necessary for the transmission of the communications, or participation in the diagnosis and treatment under the direction of the physician or mental health therapist.

Utah Rule of Evidence 506(d)(1):

> *Exceptions.* No privilege exists under this rule:
> (d)(1) Condition as element of claim or defense. As to a communication relevant to an issue of the physical, mental, or emotional condition of the patient in any proceeding in which that condition is an element of any claim or defense, or, after the patient's death, in any proceedings in which any party relies upon the condition as an element of the claim or defense; . . .

78-14-6. Writing required as basis for liability for breach of guarantee, warranty, contract or assurance of result.

> No liability shall be imposed upon any health care provider on the basis of an alleged breach of guarantee, warranty, contract or assurance of result to be

> obtained from any health care rendered unless the guarantee, warranty, contract or assurance is set forth in writing and signed by the health care provider or an authorized agent of the provider.

Utah Code Ann. § 78-24-8(4). Privileged communications.

> A physician or surgeon cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient. However, this privilege shall be deemed to be waived by the patient in an action in which the patient places his medical condition at issue as an element or factor of his claim or defense. Under those circumstances, a physician or surgeon who has prescribed for or treated that patient for the medical condition at issue may provide information, interviews, reports, records, statements, memoranda, or other data relating to the patient's medical condition and treatment which are placed at issue.

STATEMENT OF THE CASE

Nature of the Case, Course of Proceedings and Disposition Below

This action arose when a treating physician secretly agreed to serve as a paid witness for his former patient's adversary in underlying litigation, with the understanding that his cooperation would include a change to his original diagnosis. Nicholas Sorensen and his guardians Kevin and Pamela Sorensen (hereinafter collectively "Sorensen") filed this action on August 3, 2004, against defendants John P. Barbuto, individually, and John P. Barbuto, M.D., P.C. (hereinafter collectively "Barbuto") (R. 1).

On August 31, 2004, Barbuto filed a motion to dismiss Sorensen's complaint on the ground that it failed to state a claim upon which relief could be granted. (R. 13). After briefing and oral argument, the trial court dismissed the complaint, incorporating "all of the legal analyses and authorities set forth in defendants' memoranda in support and reply . . . ." (R. 155). An Order was entered on May 17, 2005 (R. 158). Sorensen filed a notice of appeal on May 31, 2005. (R. 164).

Statement of Facts

Sorensen's complaint included the following allegations:

On July 24, 1999, Nicholas Sorensen was a passenger in a single-vehicle rollover accident on I-15. Another passenger in the vehicle was killed and both Sorensen and the driver were seriously injured. Sorensen was treated by Barbuto for his head injuries and seizures for nearly a year and a half before Barbuto was removed by Sorensen's medical insurer from its list of approved providers, at which time, Sorensen began treating with other doctors. Barbuto's treatment of Sorensen included diagnostic tests and examinations, prescriptions for medicine, overseeing cognitive therapy, and other treatment for seizures and brain injury. (R. 2, ¶¶ 5, 6).

Being unable to reach a settlement with the driver's liability insurer, Sorensen filed a personal injury action entitled *Nicholas Sorensen v. Jack W. Marcelis, et al.,* Civil No. 00095711, Third Judicial District Court, Salt Lake County, Utah (the "personal injury action" or the "underlying action"). At the time the personal injury action was filed in 2000, Barbuto was still Sorensen's treating physician. (R. 2, ¶¶ 6-7).

During the course of the personal injury action, Barbuto's medical records were produced. Neither party took Barbuto's deposition. The matter was set for trial in the latter part of May 2003. Two weeks before the trial date, opposing counsel in Sorensen's personal injury action subpoenaed Barbuto to appear and give testimony at trial. Shortly thereafter, the judge continued the trial until October 2003 for reasons not related to this matter. (R. 3, ¶¶ 8, 9).

Without notice to the Sorensens or their counsel, and without authorization by the Sorensens, Barbuto continued to engage in *ex parte* contact with opposing counsel in the personal injury action, with Barbuto agreeing to act as an expert witness against his former patient. (R. 3, ¶ 9).

On August 1, 2003, opposing counsel provided medical records and other information to Barbuto and asked him to give his opinions about "what has been going on with Mr. Sorensen since you last saw him," and to address "to what degree his current issues are as a result of the [brain] injury and what those issues might be as a result of problems Mr. Sorensen had prior to the accident." The letter also requested that Barbuto contact counsel to discuss his opinions and several other issues that they would like him to address. (R. 40, ¶ 5).

Pursuant to this *ex parte* request, Barbuto prepared an extensive 10-page report, dated August 11, 2003. After orally discussing his opinions with opposing counsel, Barbuto was instructed not to send the written report to counsel, an instruction which he obeyed. (R. 40, ¶ 6).

After being retained by opposing counsel, Barbuto changed his original treating diagnosis of seizure disorders and began opining that Sorensen was not suffering from seizures after all; rather, his problems were in large part psychological and social in origin (a standard theme in nearly all of Barbuto's reports when hired by the defense). (R. 3-4, ¶¶ 10-12).

Approximately two weeks before the October 2003 trial, the *ex parte* contacts between Barbuto and opposing counsel were discovered by chance during the deposition of

another witness to the case. Immediately thereafter, Sorensen's counsel met with Barbuto and scheduled his deposition for September 30, 2003. During such deposition, Sorensen's counsel learned for the first time that opposing counsel had retained Barbuto, that Barbuto had altered his treating opinions, and that counsel and Barbuto had agreed between themselves to withhold this information from Sorensen's counsel. An emergency motion in limine was filed, and the Hon. William B. Bohling excluded the testimony of Barbuto and his new opinions. (R. 4, ¶ 11).[1]

Barbuto is well-known in the legal community for his extreme defense biases and his close relationship with insurers and insurance defense counsel. Barbuto has made hundreds of thousands of dollars a year doing so-called independent medical examinations for the defense, rarely, if ever, doing any on behalf of a plaintiff. He has admitted performing approximately 200 IMEs per year, all for the defense, rendering the predictable opinion in nearly every case, if not all cases, that the plaintiff's pain and other problems primarily or completely have their origin in psychological and/or secondary gain. (R. 4, ¶ 12).

Because the defense bar provides the vast majority of his income, Barbuto does not hesitate (as in this case) to change or spin his own treating medical opinions to favor the defense once a claim is made, all for the purpose of enhancing his own personal monetary

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[1] Barbuto represented in his reply memorandum below that the sole basis upon which Sorensen sought exclusion of Barbuto's testimony was that he was not designated timely as an expert. (R. 128 n. 2). That was incorrect. The court may take judicial notice of the actual court filing by Sorensen in the underlying case, a copy of which is included in the Addendum hereto as Exhibit 3. The motion emphasized the violation of Sorensen's rights as a patient, breach of confidentiality, and other impropriety of Barbuto's conduct, apart from any timeliness issues. *See id.*

gain and to advance a strong philosophical opposition to the legal compensation system in America. (R. 4, ¶ 13).

Barbuto's breach of duties caused Sorensen emotional distress, anguish and anxiety, and some financial loss. (R. 7, 9, ¶¶ 19, 35).

SUMMARY OF ARGUMENT

It is well established in the law, and was not contested below, that an implied contractual relationship exists between physicians and their patients. The trial court erroneously adopted Barbuto's argument, however, that no claim may be brought against a physician for breach of an implied contract unless the contract is in writing. (Indeed, the very notion that something implied must be in writing is counterintuitive.)

By its terms, Utah Code Ann. § 78-14-6 limits only those claims for breach of contract that are based upon an allegation that the physician promised or warranted a particular result. That and similar statutes were enacted in response to the peculiar evidentiary and related problems posed by that particular type of contract claim, problems that are not presented when a duty does not depend on contested testimony, but rather is implied as a matter of law.

The appellee's argument that implied contractual duties of a physician would not include confidentiality of his patients' medical information is contrary to case law, the nature of the relationship, and the long-established expectations of patients, reflected in standards promulgated by the American Medical Association and Utah Medical Association, the Hippocratic Oath, and the Health Insurance Portability and Accountability Act (HIPAA).

In addition to contract-based claims, Sorenson's complaint supports various tort theories of liability. Utah law first recognized nearly fifty years ago that a doctor owes an actionable tort duty of confidentiality to his patients. That duty was breached here in at least three separate respects.

First, the *ex parte* communications in which Barbuto engaged constitute a breach of confidentiality. A majority of jurisdictions now recognize that, even when a patient's medical condition is at issue in litigation, allowing unfettered access by opposing counsel to a treating physician does not provide any protections to the patient. Without supervision of the disclosure process, a patient has no opportunity to object to the relevance of questions asked or answers given, to clarify the scope of the medical condition actually at issue, or otherwise to evaluate or assert his patient-physician privilege. This Court recognized the need for such supervision and notice in *Debry v. Goates*, 2000 UT App 58, 999 P.2d 582, even when the patient's condition is at issue.

In the court below, Barbuto argued that he could not have committed a breach of confidentiality because he did nothing more than review records that had previously been disclosed. One of the key allegations in Sorenson's complaint, however, was that Barbuto changed the diagnosis and indications in his own medical records, by definition producing "new" information.

Finally, a breach of confidentiality arises when a physician discloses false or inaccurate medical information. The basic duty to preserve a patient's confidences includes the concept that, when utterances are made, they must be truthful.

The allegations of the complaint also support a claim for breach of Barbuto's

fiduciary duties toward Sorenson. The law in Utah and elsewhere is that the physician-patient relationship is fiduciary in nature. With the physician's fiduciary status comes several independent duties of which Sorenson's complaint alleges a breach, including the duties of confidentiality, loyalty, and refraining from taking advantage of client confidences.

A separate claim for negligence arises if the fact finder believes Barbuto's claim that he sincerely changed his mind about his earlier diagnosis. As a fiduciary, Barbuto owed a duty to disclose subsequently acquired information that he knew would make untrue or misleading a previous representation. Barbuto also owed a duty to disclose information that a reasonable patient would consider material, which encompasses a reversal of his own longstanding diagnosis.

Barbuto's alleged conduct also supports a claim for invasion of privacy. The only way for Sorenson to ameliorate the effect of Barbuto's improper conduct required that Barbuto's deposition, including its aspersions against Sorenson, be made a matter of public record. Additionally, the circumstances allow an inference that a sufficiently large number of people received Sorenson's private information, or that no minimum number of recipients was required because the disclosure was made in breach of a trust.

The allegations of Sorenson's complaint, if believed by a fact finder, establish outrageous conduct sufficient to sustain a claim for intentional infliction of emotional distress. The complaint alleges, among other things, the breach of a patient's confidences and the reversal of a physician's original diagnosis in furtherance of the physician's personal agenda, both of which are reprehensible.

Sorenson's claim for negligence was not subject to dismissal on the ground that Barbuto's actions were intentional. Intentional disclosures can be negligently made, and both this Court and the Utah Supreme Court have long held that allegations of negligent and intentional conduct can co-exist on the "continuum" of culpability.

Finally, the trial court erred in adopting Barbuto's argument that damages were not sufficiently pled. By definition, the general damages that flow naturally from a breach of trust cannot be pled with specificity. Additionally, the complaint alleges that Sorenson incurred economic loss, e.g., attorney fees and expense, as a result of Barbuto's breaches, which is all that is required in an initial pleading.

ARGUMENT

Standard of Review of a Motion to Dismiss

A motion to dismiss for failure to state a claim is "a severe remedy and should be granted by the trial court only if it is clear that a party is not entitled to relief under any state of facts which could be provided in support of its claim." *Colman v. Utah State Land Bd.*, 795 P.2d 622, 624 (Utah 1990). In reviewing a motion to dismiss, the Court must construe the facts in the complaint liberally, and consider all reasonable inferences that may be drawn from them in the light most favorable to the plaintiffs. *Busche v. Salt Lake County*, 2001 UT App 111, 26 P.3d 862; *Haymond v. Bonneville Billing & Collections, Inc.*, 04 UT 27, 89 P.3d 171.

Under Utah's notice pleading requirements, most claims need not be pled with specificity in order to withstand a 12(b)(6) motion, so long as the complaint gives fair notice of the nature and basis of the claim asserted, and a general indication of the type of

litigation involved. *Busche, supra*, citing *Fishbaugh v. Utah Power & Light*, 969 P.2d 403, 406 (Utah 1998); *Hill v. Allred*, 2001 UT 16, ¶ 14, 28 P.3d 1271 (even with respect to fraud claims that must be pled with specificity, "liberalized pleading rules" still apply, requiring nothing more than "fair notice of the nature and basis or grounds of the claim and a general indication of the type of litigation involved").

Introduction

In this case, a physician is alleged to have made unauthorized and/or false disclosures about a former patient's medical condition to an adverse party in litigation for the physician's personal gain. The trial court held that no cause of action can be maintained under Utah law for such alleged misconduct. That ruling, however, contradicts both Utah law and that of most other jurisdictions.

As discussed below, most courts in the United States recognize a cause of action for alleged breach of confidentiality by a physician, typically based upon one or more of the following theories: 1) breach of implied contractual duties; 2) breach of confidentiality and/or fiduciary duties, and 3) invasion of privacy. In *McCormick v. England*, 328 S.C. 627, 494 S.E.2d 431, 435-36 (1994), the court summarized the then-emerging state of the law:

> The modern trend recognizes that the confidentiality of the physician-patient relationship is an interest worth protecting. A majority of the jurisdictions faced with the issue have recognized a cause of action against a physician for the unauthorized disclosure of confidential information unless the disclosure is compelled by law or is in the patient's interest or the public interest. . . . The jurisdictions that recognize the duty of confidentiality have relied on various theories for the cause of action, including invasion of privacy, breach of implied contract, medical malpractice, and breach of a fiduciary duty or a duty of confidentiality.

Id. at 435-36; *see also* Judy E. Zelin, Annotation, "Physician's Tort Liability for Unauthorized Disclosure of Confidential Information About Patient," 48 *A.L.R.4th* 668 (compiling cases); David A. Elder, *Privacy Torts*, § 5.2 ("the clear modern consensus of the case law has imposed a legal duty of confidentiality or a fiduciary duty" under physician-patient relationship); 3 *Modern Tort Law: Liability and Litigation (2d ed.)*, § 25:8 (categorizing theories of liability against physician for unauthorized disclosures).

I. THE TRIAL COURT ERRED IN RULING THAT NO CLAIMS FOR BREACH OF CONTRACT CAN BE ASSERTED AGAINST A PHYSICIAN UNLESS THE ALLEGED CONTRACT IS IN WRITING.

Sorensen's first cause of action was for breach of implied contractual duties arising out of the physician-patient relationship. It is well established in the law that such duties exist between a physician and his patient. *See, e .g., Leger v. Spurlock*, 589 So.2d 40, 42 (La. App. 1 Cir. 1991); *Stubbs v. North Memorial Medical Center*, 448 N.W.2d 78, 82 (Minn. App. 1989); *MacDonald v. Clinger*, 84 A.D.2d 482, 486, 446 N.Y.S.2d 801 (1982); *Bryson v. Tillinghast*, 749 P.2d 110 (Okla. 1988); *Horne v. Patton*, 291 Ala. 701, 287 So.2d 824 (1973).

In the court below, however, Barbuto successfully sought dismissal of Sorensen's contract claim on the ground that the implied-by-law contract between them was not in writing. Barbuto's principal argument was that all contract-based claims against doctors are barred by Utah Code Ann. § 78-14-6 unless the contract is in writing. The assertion of that argument, however, required a few well-placed ellipses. Without Barbuto's omissions, Section 78-14-6 reads, in its entirety:

> 78-14-6. Writing required as basis for liability for breach of guarantee, warranty, contract or assurance of result.
>
> No liability shall be imposed upon any health care provider on the basis of an alleged breach of guarantee, warranty, contract or assurance of result to be obtained from any health care rendered unless the guarantee, warranty, contract or assurance is set forth in writing and signed by the health care provider or an authorized agent of the provider.
>
> In his argument below, Barbuto, however, abbreviated the statutory text thus:
>
> No liability shall be imposed on any health care provider on the basis of an alleged breach of . . . contract . . . unless the . . . contract . . . is set forth in writing and signed by the health care provider or an authorized agent of the provider.

(R. 18; ellipses in original).

Eliminating all of the qualifying words, Barbuto argued that "Utah law precludes a contract claim against a physician absent a written contract signed by the physician or his designated agent." (R. 18.) The trial court adopted Barbuto's reasoning, even though, when read in full, the statute by its terms addresses only guarantees, warranties, contracts, or assurances "of result to be obtained from any health care rendered."

The limited scope of the statute, pertaining to promises of a particular result, is not accidental. Rather, it stems from the history of this specific type of claim. "[T]he courts have often said that in the absence of a special contract, a physician does not warrant the success of his treatment, nor even that beneficial results will occur . . . ." Jack W. Shaw, Jr., Annotation, "Recovery Against Physician on Basis of Breach of Contract to Achieve Particular Result or Cure," 43 *A.L.R.3d* 1221, § 2. *See, e.g., Nauman v. Harold K. Beecher & Assoc.*, 24 Utah 2d 172, 467 P.2d 610, 615 (1970) ("The law does not impose

upon a physician or surgeon the duty of guaranteeing that his treatment will achieve good results"), and cases cited.

Not surprisingly, given the stated exception, plaintiffs' attorneys began to allege the existence of a special contract by physician defendants to achieve particular results. In the 1960s and early 1970s, a plethora of opinions were issued involving such alleged contracts or warranties. *See, e.g.,* 43 A.L.R.3d 1221, §§ 3-6. The principal dispute in nearly all such cases was whether an agreement existed. *Id.*, § 2 ("The problem, therefore, appears to be one of proof that such an agreement was or was not made.") The alleged promise was usually oral, posing endless 'he said-she said' evidentiary disputes and making it difficult for defendants to seek early resolution of the lawsuit. The problem was exacerbated by a blurring in some patients' minds between "therapeutic reassurances" ("you'll be all right") and actionable representations or promises of a particular result. See *id.*, and *id.* § 2.

To address this problem, states began to require that claims against health care providers based upon alleged contracts or warranties of a particular result be in writing. *See, e.g., Edwards v. Germantown Hospital*, 736 A.2d 612, 615 (Pa. Super. 1999) (purpose of 1975 statute requiring written contract was to codify law that physician is neither a warrantor nor a guarantor of result); *Zapata v. Rosenfeld*, 811 S.W.2d 182 (Ct. App. – Houston, 1991) (applying Texas statute requiring written promise or warranty of particular result to enforce alleged promise).

Consistent with other states, Utah adopted Utah Code Ann. § 78-14-6 in 1976. The statutes accomplished their goal; very few cases claiming promised results have been

brought in the past two decades. *See* 43 *A.L.R.3d* 1221, §§ 3-8. By their terms, however, the statutes apply only to claims of a contract (guarantee, warranty, or assurance) of a particular *result*, not other contracts. *See, e.g.*, *Jackson v. Bumgardner*, 71 N.C. App. 107, 321 S.E.2d 541 (1984), *aff'd in part and rev'd in part on other grounds,* 347 S.E.2d 743 (N.C. 1986) (statute providing that "[n]o action may be maintained against any health care provider upon any guarantee, warranty or assurance as to the result of any medical, surgical or diagnostic procedure or treatment unless . . . in writing and signed by the provider or by some other person authorized to act for or on behalf of such provider" did not apply to claim for breach of contract not involving promise to yield specific result).[2]

Other types of contract claims, ones which do not present the same unique problems of proof, simply do not fall within the statute's scope. In the case of an implied contractual duty to retain confidences, for example, the law implies the duty; therefore, it is immaterial whether the physician also made representations in that regard. The trial court erred in construing Section 78-14-6 as applying to all contract claims, regardless of the subject matter.

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[2] The statute uses a string of similar words ("guarantee, warranty, contract or assurance") because a cause of action may differ depending on whether a physician's statement is characterized as a promise or a representation. "Technically, where the defendant has made a promise to the plaintiff concerning the forthcoming operation or procedure, the cause of action may properly be characterized as a contract action, whereas if the defendant has made some representation of fact concerning the result of the operation or procedure, the action would properly be one for breach of warranty." Daniel P. Kapsak, "Cause of Action Against Physician for Breach of Contract or Warranty," 22 *Causes of Action* 779 (2004), § 3. Section 78-14-6 covers all the bases.

Barbuto also argued below that, assuming the existence of an enforceable contract, the only implied duties that arose "would deal with the professional diagnosis and treatment of the patient's condition. Plaintiffs are not claiming Mr. Sorensen's failure to receive the 'fruits of the contract,' Dr. Barbuto's professional diagnosis and treatment." (R. 19).

That argument artificially narrows the scope of the implied contractual relationship between a physician and patient. The "fruits of the contract" inherently include the basic concept of confidentiality. In *Aufrichtig v. Lowell*, 85 N.Y.2d, 650 N.E.2d 401 (1995), a physician allegedly provided a false affidavit to an insurance company that was adverse to a patient with respect to a claim for benefits. New York's high court rejected an argument similar to Barbuto's, that the only duty owed to a patient was of competent medical treatment, not of confidentiality:

> The physician in this case would limit his duty to the provision of competent medical treatment to his patient. Defendant, however, has ignored the central thrust of this case and confused simple and ordinary medical malpractice with the distinct yet related duty, when required, of providing truthful information about the patient. Unassailably, part of a physician's duty to the patient, when authorized to supply otherwise confidential information to others—either as a result of a patient's express consent or waiver by the condition having been placed in issue—includes truthful utterances, particularly, as here, when delivered under oath and with awareness that a false statement will be relied upon the detriment of the patient.

650 N.E.2d at 404; *see also* Elder, *supra*, § 5.2 (stating that a majority of courts have imposed actionable confidentiality requirement "as a 'special and peculiar fiduciary relationship' imposing an 'additional duty springing from, but extraneous to,' the contract").

Implied contractual duties derive from the nature of the relationship and the reasonable expectations of the parties to the contract. *Machan v. Unum Life Insurance Company of America*, 2005 UT 37, ¶¶ 12, 16, 19 n. 2, 30, 116 P.3d 342. In defining those expectations, a court may consider external standards governing physicians' conduct. *Id.*, ¶ 30 ("Even in the absence of a private right of action under [claims handling statute], we would deem it proper for a court to take into account the legislature's mandates, as well as the insurance commissioner's regulations, regarding insurance adjuster duties when making a determination of the parties' reasonable expectations under the contract").

In this case, apart from a lack of support in the case law, any argument that a physician's implied contractual duties do not include confidentiality is inconsistent with well-established standards of conduct that form part of a patient's reasonable expectations. All physicians, for example, are required to abide by the AMA Principles of Medical Ethics. (The Utah Medical Association has expressly adopted the AMA Principles. (R. 83-85).) Those standards require physicians to, among other things "respect the rights of patients, of colleagues, and of other health professionals, [and] safeguard patient confidences within the constraints of the law." AMA E-Principles of Medical Ethics, Preamble, No. 4 (2002).

The AMA Principles also provide that:

> The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will

> respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

AMA E-Principles, E-5.05 (1994).

A patient's expectation of confidentiality also "has its genesis in the Hippocratic Oath, which states in pertinent part: 'Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all such should be kept secret.'" *McCormick*, 494 S.E.2d at 435, quoting *Taber's Cyclopedic Medical Dictionary* 902 (17th ed. 1993); *Hammonds v. Aetna Casualty & Surety Co.*, 243 F.Supp. 793, 801 (N.D. Ohio 1965) ("Almost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence").

A patient's reasonable expectation of confidentiality is further evidenced by the widely publicized privacy protections afforded by the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 201, *et seq.* Among other things, HIPAA precludes a physician from unilaterally disclosing medical information even when the patient's condition is at issue in litigation. A health care provider may disclose protected health information only upon receiving satisfactory assurance that the requesting party has notified the subject of the request. *See* 65 Fed.Reg. at 82,814-15; *Law v. Zuckerman*,

307 F.Supp.2d 705, 710-711 (D.Md. 2004) (HIPAA bars disclosures absent express consent of the patient or court order).[3]

The considerations articulated by one of the earliest courts to recognize an implied contractual duty of confidentiality apply with even greater force today:

> Any time a doctor undertakes the treatment of a patient, and the consensual relationship of physician and patient is established, two jural obligations (of significance here) are simultaneously assumed by the doctor. Doctor and patient enter into a simple contract, the patient hoping that he will be cured and the doctor optimistically assuming that he will be compensated. As an implied condition of that contract, this Court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission. . . . The promise of secrecy is as much an express warranty as the advertisement of a commercial entrepreneur. Consequently, when a doctor breaches his duty of secrecy, he is in violation of part of his obligations under the contract.

Hammonds, 243 F.Supp. at 801.

In light of patient expectations fostered by the medical community over the past two thousand years, it was error for the trial court to adopt Barbuto's argument that the duties arising from the implied contractual relationship between physician and patient do not include confidentiality. Moreover, that duty cannot retroactively evaporate upon the termination of the relationship. Information learned by a physician in the course of medical treatment does not suddenly lose its confidential status when the patient transfers to another health care provider.

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[3] The trial court ruled that no private right of action exists under HIPAA. Sorensen acknowledges that, to date, no court has recognized such a claim. *See, e.g., Bradford v. Semar*, 2005 WL 1806344 (E.D.Mo. 2005, listing cases). Accordingly, Sorensen does not argue a direct cause of action under HIPAA in the present appeal. However, HIPAA and its regulations remain evidence of the standard of care, Barbuto's knowledge and disregard of the illegality of his conduct, and of Sorensen's reasonable expectations.

Sorensen's breach of contract claim against Barbuto is not barred by the absence of a written contract. Consequently, the trial court's judgment must be reversed.

II. THE TRIAL COURT ERRED IN RULING THAT NO CLAIM CAN BE MAINTAINED FOR BARBUTO'S ALLEGED BREACH OF CONFIDENTIALITY.

In the court below, Barbuto did not dispute that a physician owes an actionable tort duty of confidentiality. As the Utah Supreme Court wrote in *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814, 817 (1958), it is obligatory upon a doctor not to reveal information obtained in confidence in connection with the diagnosis or treatment of his patient, and "if the doctor violates that confidence and publishes derogatory matter concerning his patient, an action would lie for any injury suffered." S*ee also Newman v. Sonnenberg*, 2003 UT App 401, ¶ 9, 81 P.3d 808 ("[F]rom the moment a patient enters a doctor's office, fills out forms, and speaks to a doctor, that doctor owes the patient a duty of reasonable care (e.g., a duty of confidentiality and duty not to exploit the patient) . . . .").

A key basis for the Supreme Court's observation in *Berry* was the reality that "[a physician's] professional status and his duty to keep the confidence of his patient tend to endow information he gives with more than ordinary credibility." 331 P.2d at 819. In this case, Barbuto's alleged willingness to change his diagnosis for financial consideration not only breached Sorensen's confidence, but also deprived Sorensen of an important component in his underlying trial, objective, truthful testimony by a treating physician. As the court observed in *Aufrichtig*, 650 N.E.2d at 405:

> The defendant treating physician here was the crucial link and indispensable source of knowledge and pertinent facts about Mrs. Aufrichtig's case and condition for the purpose of her insurance medical benefits. Others would

> ordinarily be expected to rely on this unique source and did so, in the most formal and official setting, according to this record. His assertion was not a casual expression of belief, but was a voluntary and willful affirmation of the crucial false facts and professional opinion. Plaintiffs had engaged his services rightfully expecting not only reasonable medical care and competence, but also truthful, continuing, necessary supply of medical information, when required.

Id. at 405.

In contending that no breach of confidentiality can be maintained in this case, Barbuto made two assertions. First, he argued that Sorensen's complaint did not specify the confidential information that had been disclosed. (R. 101-102, 106). Second, Barbuto argued that, once a patient files a claim involving personal injury, there are no limits, restrictions, or duties of any kind regarding a physician's disclosure of medical information to third parties. (R. 20-21). Because the arguments are related, they are addressed together below.

Barbuto's first argument, that Sorensen was required to identify the specific confidential information disclosed, is without merit. U.R.Civ.P. 8 contemplates basic notice pleading; specificity requirements are limited to those claims identified in U.R.Civ.P. 9. The complaint alleges that confidential information was disclosed (R. 6, ¶ 17), and there is no provision in the Rules of Civil Procedure requiring further elucidation in the initial pleading. That is the purpose of discovery. (Indeed, considering that, by definition, a patient is not privy to the content of *ex parte* communications, such a pleading requirement would essentially preclude all claims.)

In any event, though, the complaint does put Barbuto on notice of what Sorensen claims comprised Barbuto's breach of duty. The duty was breached in at least three

separate ways: 1) through improper *ex parte* communications; 2) disclosure of mental impressions and other information regarding Sorensen that was not in Barbuto's records; and 3) disclosure of false or inaccurate information.

1. The *ex parte* communications between Barbuto and opposing counsel were a breach of confidentiality.

The complaint alleges that, without notice to Sorensen, Barbuto voluntarily engaged in *ex parte* discussions with opposing counsel regarding Sorensen's medical condition. Although some courts have ruled otherwise, an emerging majority of courts appears to hold that, when a patient places his medical condition at issue, information relevant to that condition may be disclosed only pursuant to proper (formal) means. See Daniel P. Jones, Annotation, "Discovery: Right to Ex Parte Interview with Injured Party's Treating Physician," 50 *A.L.R.4th* 714 (compiling cases on both sides of issue); Philip H. Corboy, "Ex Parte Contacts Between Plaintiff's Physician and Defense Attorneys: Protecting the Patient-Litigant's Right to a Fair Trial," 21 *Loy. U. Chi. L. J.* 1001, 1003 (1990) ("Recent state court decisions, including several overruling prior precedent, now reflect a strong majority view that condemns ex parte conferences"), and cases cited.

Even when a patient has waived his privilege or a privilege is deemed not to exist by virtue of asserting a claim, "the question remains by what procedures and subject to what controls the exchange of information shall proceed." *Jones v. Asheville Radiological Group*, 129 N.C.App. 449, 500 S.E.2d 740, 748 (1998). The waiver or absence of a privilege does not determine the means by which otherwise confidential

information is disclosed. *See, e.g., Morris v. Consolidation Coal Co.*, 191 W.Va. 426, 446 S.E.2d 648, 655 (1994) ("The patient's implicit consent . . . is obviously and necessarily limited; he does not consent, simply by filing suit, to his physician's discussing his medical confidences with third parties outside court-authorized discovery methods, nor does he consent to his physician's discussing the patient's confidences in an *ex parte* conference with the patient's adversary"); *Manion v. N.P.W. Med. Ctr.*, 767 F.Supp. 585, 593 (M.D. Pa. 1987) (prohibition against *ex parte* communications "affects defense counsel's methods, not the substance of what is discoverable"); *Duquette v. Superior Court*, 161 Ariz. 269, 272, 778 P.2d 634, 637 (App. 1980) ("even where the physician-patient privilege has been impliedly waived, the holder of the privilege waives only his right to object to discovery of pertinent medical information which is sought through the formal methods of discovery authorized by the applicable Rules of Civil Procedures").

Absent any supervision by the patient over the disclosure, a risk is posed that discussions will stray into improper areas. *Jones*, 500 S.E.2d at 748 ("Requiring defendants to abide by formal discovery rules in obtaining medical records from a non-party physician, even where the patient has waived the physician-patient privilege, protects the patient from disclosure of aspects of her mental and physical health which may be irrelevant or otherwise inadmissible in court").

By their very nature, *ex parte* communications deprive the patient of any knowledge or control over what actually transpires. "The plaintiff's counsel rarely is notified and may learn of the interviews only much later. It is virtually impossible to

determine whether disclosures of privileged confidences or other improprieties occurred during the interviews. In essence, defense counsel has been able to take advantage of the limited waiver of the patient privilege while evading the adversarial safeguards embodied in formal discovery." Corboy, 21 *Loy. U. Chi. L. J.* at 1007.

The *Morris* court summarized its concerns with *ex parte* contact between a treating physician and opposing counsel thus:

> Even if no improper pressure were brought to bear on a physician, it would, nevertheless, often be difficult for the defense to determine on its own if and to what extent the physician-patient privilege was waived. Parties may be in substantial disagreement over the kinds of injuries put in issue by the pleadings. . . . Whether a physical or mental condition is in controversy often requires careful judicial scrutiny and not a mere cursory reading of the complaint. . . . The determination of whether a medical condition is in controversy often requires specialized knowledge of the relevant factors which a court may look to in deciding a case. . . . By restricting disclosure to that obtainable pursuant to statute, court rule, or express consent, the patient's attorney will be afforded an opportunity to object to the disclosure of medical information that is remote, irrelevant, or otherwise improper, the court will be afforded an opportunity to regulate disclosure, and needless lawsuits for breach of confidence will be avoided.

446 S.E.2d at 656, *quoting Anker v. Brodnitz*, 413 N.Y.S.2d 582 (N.Y. Sup. Ct. 1979), aff'd, 73 A.D.2d 589, 422 N.Y.S.2d 887 (1979), appeal dismissed, 411 N.E.2d 783, 795 (1980) (court's ellipses); *see also Jordan v. Sinai Hospital*, 171 Mich.App. 328, 429 N.W.2d 891 (1988), *overruled in part on other grounds*, 435 N.W.2d 347 ("The physician's ethical duty of loyalty and the implied promise of confidentiality which arise upon treatment favor a bar on ex parte interviews, as does the fiduciary nature of the relationship between patient and physician. The formal rules of discovery provide defense counsel with all relevant information").

One of the leading decisions recognizing the need for a limitation on the means of disclosing otherwise discoverable medical information is *Petrillo v. Syntex Laboratories, Inc.*, 148 Ill. App. 3d 581, 499 N.E.2d 952 (1986). After a comprehensive analysis of the arguments both for and against *ex parte* communications, the court concluded that public policy militates against such unrestricted contact:

> [W]e believe that modern public policy strongly favors the confidential and fiduciary relationship existing between a patient and his physician. We further believe that this public policy arises from the fact that society possesses an established and beneficial interest in the sanctity of the physician-patient relationship. We find this public policy to be reflected in at least two separate indicia: (1) the promulgated code of ethics adopted by the medical profession and upon which the public relies to be faithfully executed so as to protect the confidential relationship existing between a patient and his physician; and (2) the fiduciary relationship, recognized by courts in Illinois as well as courts throughout the United States, which exists between a patient and his treating physician. . . . [W]e believe, for the reasons set forth above, that ex parte conferences between defense counsel and a plaintiff's treating physician jeopardize the sanctity of the physician-patient relationship, and, therefore, are prohibited as against public policy.

499 N.E.2d at 957.

An argument that, in hindsight, particular information disclosed turned out to be admissible anyway – the judicial equivalent of "no harm, no foul" – does not override the concern that protection of a patient's basic rights should not be left to opposing counsel and a doctor (particularly one being paid by the opposing party). *See, e.g., Crescenzo v. Crane*, 350 N. J. Super. 531, 796 A.2d 283 (2002) ("The determination of whether the records are ultimately admissible should not in the first instance by made be a doctor responding to a subpoena or an attorney who violates the Rule and improperly subpoenas the records. . . . That determination must be made in a courtroom by a judge consistent

with appropriate due process concerns including notice and an opportunity to be heard"); *see also Roosevelt Hotel Ltd. Partnership v. Sweeney,* 394 N.W.2d 353, 357 (Iowa 1986) ("Placing the burden of determining relevancy on an attorney, who does not know the nature of the confidential disclosure about to be elicited, is risky. Asking the physician, untrained in the law, to assume this burden is a greater gamble and is unfair to the physician").

Barbuto contends, however, that once a patient's medical condition is at issue in a lawsuit, there are no restrictions on the manner or type of disclosures that a physician can make, because at that point "the patient's privacy becomes moot." (R. 27; also R. 25 (claiming that patient has no legitimate expectation of privacy at all once claim is filed)). Barbuto argued that Utah Rule of Evidence 506(d)(1) and Utah Code Ann. § 78-24-8 allow unfettered *ex parte* communications between physicians and opposing counsel (and anyone else, actually, under Barbuto's theory).

This Court has already rejected that argument. In *Debry v. Goates*, 2000 UT App 58, 999 P.2d 582, *cert. denied*, 9 P.3d 170 (2000), without notice to his patient, defendant Goates provided an affidavit regarding the patient's health to opposing counsel in a hotly contested divorce action. In a subsequent lawsuit by the patient, Goates argued that he was permitted to do so by Rule 506 and Section 78-24-8(4) because the patient's condition was at issue in the underlying case. The trial court agreed, entering summary judgment for the defendant.

On appeal, this Court reversed. The Court initially noted that Section 78-24-8(4) has been superseded by U.R.E. 506(d)(1), and therefore Goates could not rely on the

statute to excuse his conduct. *Id.* at ¶ 24 n. 2 ("The statutory privilege has no further effect. Physician-patient and therapist-patient privileges are now exclusively controlled by Rule 506").[4]

The Court then addressed Dr. Goates's claimed entitlement to *ex parte* disclosures under U.R.E. 506. The Court first concluded that the exception to physician-patient privilege in Rule 506 applies any time a patient's medical condition is placed at issue in litigation, even if done so by another party. Consequently, Mrs. Debry's medical condition was at issue at the time of the disclosure. *Id.*, ¶¶ 25-27.

However, the Court disagreed that, merely because his patient's medical condition was at issue, Dr. Goates had free rein in discussing that condition with opposing counsel. The Court observed that, "although this exception to the privilege is broad enough to let a nonpatient raise the patient's mental state as an issue in proceedings, access to medical records is still constrained." *Id.*, ¶ 26, citing *State v. Cardall*, 1999 UT 51, ¶ 30, 982 P.2d 79. Even when Rule 506 applies, "[a] nonpatient 'does not have the right to examine all of the confidential information or to search through files without supervision.'" *Id.* "If, after review, the court determines the records contain material evidence, the records

[4] Barbuto acknowledged below that "Rule 506 is intended to supersede § 78-24-8, at least with respect to the first two sentences in the statute which establish the privilege," but argued that he can still rely on the statute because it has "never been repealed" and is not inconsistent with Rule 506. Whether it has been repealed is immaterial; the superseded statute is of no effect. As for alleged inconsistency, it is significant that the statute is the only source to which Barbuto can point in claiming an entitlement to unsupervised, undisclosed *ex parte* disclosures. (R. 21 n. 1, asserting that under the statute, "a treating physician is free to provide information and interviews" without restriction.). The fact that Barbuto must cite the superseded statute rather than Rule 506 to make such an argument illustrates the extent to which the two provisions differ.

should be exposed only to the extent necessary to present the evidence, thereby striking a balance between the important interests of physician-patient confidentiality and the pursuit of a claim or defense." *Id.*

As in this case, Dr. Goates made no effort to safeguard his patient's confidentiality. "From all that appears, Dr. Goates voluntarily furnished an affidavit about his patient's mental condition to her adversary in divorce litigation," the Court observed. "Dr. Goates gave his affidavit without a court order, without a subpoena, and without even notifying Debry. She had no opportunity to assert her privilege." *Id.*, ¶ 27.

The Court held that, "under these circumstances, a patient must at least be afforded the opportunity for protection. As part of a therapeutic relationship, a doctor or therapist has an obligation to protect the confidentiality of his patients that transcends any duty he has as a citizen to voluntarily provide information that might be relevant in pending litigation." *Id.*, ¶ 28. "Before disclosing confidential patient records or communications in a subsequent litigation," the court wrote, "a physician or therapist should notify the patient. Even if the communications may fall into this exception to the privilege, the patient has the right to be notified of the potential disclosure of confidential records. Such notice assures that the patient can pursue the appropriate procedural safeguards in court to avoid unnecessary disclosure." *Id.*[5]

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[5] This ruling is consistent with the fact that, even in the few states that do not recognize an evidentiary patient-physician privilege at all, a physician's duty of confidentiality is held to preclude voluntary disclosure. *See McCormick, supra* (recognizing cause of action for unauthorized disclosure even though South Carolina does not have a testimonial privilege for physicians; "the terms 'privilege' and 'confidences' are not synonymous, and a professional's duty to maintain his client's confidences is independent

It is undisputed in this case that Barbuto made no attempt to notify Sorensen of his disclosures to, and discussions with, opposing counsel, let alone that he was doing so for personal gain. Moreover, notification alone will be insufficient to protect the patient's rights in most instances. A physician like Barbuto and/or an attorney is likely to refuse any oversight by the patient of the disclosure. (Indeed, Barbuto refused even to show his report to Sorensen's counsel, asserting "work product" on behalf of opposing counsel. *See* Addendum Exh. 3, Bates 6, ¶ 8). Under such circumstances, general notification that disclosures will be made does nothing to allow the patient to lodge objections as to their scope or manner. Protection of patients' rights requires, at a minimum, some form of participation by plaintiff and/or his counsel in the disclosure process, such as his presence during conversations about his medical condition, or obtaining the information through a list of questions disclosed prior to the interview, or through deposition or other court authorized procedure.

2. The complaint sufficiently alleges that Barbuto disclosed information that had not previously been disclosed.

Barbuto also argued below that he could not have breached his duty of confidentiality because he did nothing more than review records that had already been disclosed. (R. 23-24). That factual assertion ignores the allegations of Sorensen's Complaint. One of Sorensen's primary complaints is that Barbuto disclosed opinions, observations, and other information that were not in the records disclosed, for example,

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of the issue whether he can be legally compelled to reveal some or all of those confidences, that is, whether those communications are privileged").

changing his diagnosis to something far different from that stated in his own medical records. A new spin on a physician's own diagnosis is, by definition, previously undisclosed information. *See also* 1 Utah Prac., *Mangrum & Benson on Utah Evidence* (2004), Rule 506 (physician-patient privilege "applies not only to communications between patient and physician, but also to facts obtained by the physician by examination or observation").

Moreover, if Barbuto did nothing more than disclose information that had already been disclosed in the medical records, why an hours-long meeting with opposing counsel? A reasonable inference can be drawn from that fact alone that Barbuto discussed information beyond the bare content of the medical records themselves.

3. The disclosure of false information is a breach of confidentiality.

The third form of breach of confidentiality alleged in the complaint is that Barbuto changed his original, longstanding diagnosis without any basis for doing so (other than monetary gain), in other words, that Barbuto's "new" diagnosis was essentially false. A physician's duty of confidentiality includes an obligation, when disclosing confidential information, to do so truthfully. *See Aufrichtig*, 650 N.E.2d at 404 ("part of a physician's duty to the patient, when authorized to supply otherwise confidential information to others—either as a result of a patient's express consent or waiver by the condition having been placed in issue—includes truthful utterances"). Sorensen's allegations state a claim for breach of confidentiality in this aspect of Barbuto's conduct as well.

III. THE ALLEGATIONS OF THE COMPLAINT SUPPORT A CLAIM THAT BARBUTO BREACHED HIS FIDUCIARY DUTIES TO SORENSEN.

Utah law has long recognized that the physician-patient relationship is fiduciary in nature. *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980) (noting "fiduciary nature of the [physician-patient] relationship" imposes duty to disclose any material information concerning the patient's physical condition); *see also First Security Bank of Utah v. Banberry Development Corp.*, 786 P.2d 1326, 1330 (Utah 1990) (class of relationships giving rise to duty of disclosure includes "where it is either presumed in law or proved in fact that one party is in a superior or dominant position and the other in an inferior or servient position. These relations include those evolving from domestic relations as well as relations between . . . doctor and patient").

The fiduciary nature of the physician-patient relationship is widely recognized. *See, e.g., Gracey v. Eaker,* 837 So.2d 348 (Fla. 2002), and cases cited; *Eckhardt v. Charter Hospital*, 124 N.M. 549, 953 P.2d 722, 726-27 (N.M. App. 1997); *McCormick*, 492 S.E.2d at 435 ("Being a fiduciary relationship, mutual trust and confidence [in physician-patient relationship] are essential"); *Aufrichtig*, 650 N.E.2d at 404 ("The physician-patient relationship thus operates and flourishes in an atmosphere of transcendent trust and confidence and is infused with fiduciary obligations").

As a fiduciary, Barbuto owed several discrete duties implicated by his alleged misconduct.

1. Duty of confidentiality.

One of the most basic of a fiduciary's duties is confidentiality. *See, e.g., Kilpatrick v. Wiley, Rein & Fielding*, 909 P.2d 1283, 1290 (Utah 1996) ("As fiduciaries, attorneys have a legal duty 'to represent the client with undivided loyalty, to preserve the client's confidences, and to disclose any material matters bearing upon the representation of the client").

The duty not to disclose confidential information necessarily extends beyond the termination of the relationship through which the information was obtained. *Envirotech Corp. v. Callahan*, 872 P.2d 487, 496 (Utah App. 1994), *cert. denied* (former employee's fiduciary duty not to use confidential information to his advantage remained in force three years after termination). Any other conclusion would force a patient to either remain with the same health care provider in perpetuity, or subject himself to former providers' whims with respect to his confidential information. (To avoid duplication, other issues relating to confidentiality are addressed *supra* at pp. 20-30.)

2. Duty of loyalty.

Under Utah law, fiduciaries are required to be "completely loyal to their clients." *Walter v. Stewart*, 2003 UT App 86, ¶ 16, 67 P.3d 1042. Such loyalty includes a duty not to, voluntarily and for personal gain, take positions adverse to one's patient. *See, e.g., Alexander v. Knight*, 197 Pa.Super. 79, 177 A.2d 142 (1962) (physician's "confidential or fiduciary capacity as to their patients . . . includes a duty to refuse affirmative assistance

to the patient's antagonist in litigation. The doctor, of course, owes a duty to conscience to speak the truth; he need, however, speak only at the proper time").[6]

3. Duty not to take advantage of client confidences.

In addition to the foregoing duties, fiduciaries "must never use their position of trust to take advantage of client confidences for themselves or for other parties." *Walter*, 2003 UT App 86, ¶ 16. The allegations of Sorensen's complaint are that Barbuto abused his position of trust as a former treating physician for his own gain and that of an opposing party.

IV. BARBUTO'S ALLEGED ACTIONS VIOLATE THE GENERAL DUTIES OWED BY A PHYSICIAN TO A PATIENT.

It is alleged in this case that Barbuto changed his original diagnosis – upon which the patient and subsequent physicians relied for years – without telling anyone (except

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[6] A physician's duty not to turn one's self into an adversary is different from the obligation to testify truthfully, a distinction as basic as that between fact witness and an expert witness. *See* Alexander B. McNaughton and Susan McNaughton, "Divided Loyalty: The Dilemma of the Treating Physcian Advocate," 22 *Okla. City U. L. Rev.* 1051 (1997) ("There is a vast difference, however, in a treating physician testifying as a fact witness based on personal observations and as an advocate."); *Schaffer v. Spicer* 88 S.D. 36, 215 N.W.2d 134 (S.D. 1974) (allowing claims against psychiatrist who voluntarily gave affidavit to opposing counsel), quoting *Hammonds*, 243 F.Supp. at 805 ("assuming, but without deciding, that the plaintiff waived the testimonial privilege because of the deposition, this 'waiver' does not authorize a private conference between doctor and defense lawyer. It is one thing to say that a doctor may be examined and cross-examined by the defense in a courtroom, in conformity with the rules of evidence, with the vigilant surveillance of plaintiff's counsel, and the careful scrutiny of the trial judge; it is quite another matter to permit, as alleged here, an unsupervised conversation between the doctor and his patient's protagonist").

opposing counsel) that his original diagnosis was wrong.[7] In the court below, Barbuto argued that, once a physician is no longer treating a patient, he has no duty to advise his former patient of new information. (R. 108-109). That position might be tenable if this case involved new technology or some other matter that could not fairly be placed upon the original physician's shoulders. That is not Sorensen's claim, though.

Sorensen alleges that Barbuto's so-called "new information" was a conclusion that the physician's own prior diagnosis was (allegedly) erroneous. If, as Barbuto claims, his change of heart was sincere, then he owed Sorensen a duty to notify him, and/or his subsequent treating physicians, that his own original diagnosis should no longer be considered reliable. *See, e.g., First Security Bank of Utah v. Banberry Development Corp.*, 786 P.2d 1326, 1330-31 (Utah 1990) (fiduciary duty of disclosure, including between "relations between . . . doctor and patient" includes "subsequently acquired information that he knows will make untrue or misleading a previous representation that when made was true or believed to be so"), citing *Restatement (Second) of Torts*, § 551.

The duty of care generally owed by physician to patient is to exercise that degree of skill and learning ordinarily possessed and exercised, under similar circumstances, by other practitioners in his field, and to use ordinary reasonable care and diligence, and his best judgment, in applying his skill to patient's case. *Farrow v. Health Services*

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[7] As Barbuto put it during his deposition in the underlying case, his original diagnosis might have "created a mythology" in Sorensen's subsequent medical treatment. (*See* Addendum Exh. 3, Bates 61). Notably, opposing counsel's letter retaining Barbuto's services requested Barbuto to let counsel know what Barbuto thought, "as his treating physician early on in his injury, about his current condition." *Id.*, Bates 21 (emphasis added).

Corporation, 604 P.2d 474, 476 (Utah 1979). Those duties include the duty to disclose to that patient that which is in his best interests and important that he should know. *Nixdorf*, 612 P.2d at 354 n. 18. If a reasonable patient would consider the information important in the course of treatment, the information is material and disclosure is required. *Ramon v. Farr*, 770 P.2d 131 n. 6 (Utah 1989). In this case, a jury could find that a complete reversal in his diagnosis by the physician who treated Sorensen for the first year and a half after his accident would be important to know.

IV. THE TRIAL COURT ERRONEOUSLY RULED THAT SORENSEN COULD NOT MAINTAIN A CLAIM FOR BREACH OF PRIVACY.

One who invades the right of privacy of another is subject to liability for resulting harm to the interests of the other. The right of privacy is invaded by, among other things, unreasonable publicity given to the other's private life, or publicity that unreasonably places the other in a false light before the public. *Cox v. Hatch*, 761 P.2d 556, 564 (Utah 1988).

Barbuto did not dispute below that his modified report placed Sorensen in a false light. Rather, his sole basis for seeking dismissal of Sorensen's breach of privacy claim was that there was no public disclosure, and that Sorensen had no legitimate expectation of privacy. (The fact that a patient maintains an expectation of privacy, albeit limited, in a personal injury lawsuit has been addressed above, *see* pp. 20-30, *supra*.)

With respect to whether the disclosure was sufficiently public, the Utah Supreme Court has indicated that disclosure of private information "to a small group of persons . . . does not constitute public disclosure." *Shattuck-Owen v. Snowbird Corp.*, 2000 UT 94, ¶

12, 16 P.3d 555. That is not dispositive of Sorensen's claim, however. In the underlying case, the only way for Sorensen to obtain partial relief from the effects of Barbuto's misconduct required that Barbuto's deposition be filed with the court in the underlying case, thus becoming a matter of public record. That is the epitome of public disclosure.[8]

Additionally, there is no specific "body count" required to maintain an action for invasion of privacy. Sheila D'Ambrosio, "Invasion of Privacy By Public Disclosure of Private Facts," 43 *Am. Jur. Proof of Facts 2d* 449 ("While an actionable disclosure is generally one made only to a large number of people, it cannot be said that disclosure of embarrassing private facts to a comparatively small number of people will automatically be insufficient to constitute a public disclosure. There is no magic formula or 'body count' that can be given to permit counsel to determine with certainty whether the number of persons to whom private facts have been disclosed will be sufficient in any particular case to satisfy the public disclosure requirement").

Barbuto's argument below failed to afford Sorensen all reasonable inferences that could be drawn from the complaint. An allegation that private information was disclosed to opposing counsel inherently encompasses others to whom counsel ordinarily might reasonably be expected to relay such information. In this case, it is reasonable to infer that counsel relayed the information to his client, to the client's liability insurance carrier

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[8] Barbuto represented to the court below that he "only testified at deposition because plaintiffs required him to do so." (R. 108 at 10). That assertion was misleading. Once the covert arrangement between his former treating physician and opposing counsel was discovered, there was no other way for Sorensen to explore what had transpired and to advise the court. As noted above, Barbuto refused initially even to give Sorensen a copy of his report, invoking "work product" on behalf of opposing counsel.

– who was making decisions regarding settlement – as well as to other expert witness(es) and other employees of his firm. (The specific identities of these others can only be obtained through discovery.)[9]

A minimum "body count" rule would not apply in this case in any event, because the disclosure was made in violation of a duty of trust. *See* 77 C.J.S. *Right of Privacy and Publicity* (2005), § 25 ("A communication to one individual, or a few, or to a small group of people absent breach of contract, trust or other confidential relationship, will not give rise to liability"; emphasis added). For each of these reasons, the trial court erred in dismissing Sorensen's claim for invasion of privacy, and the judgment should be reversed.

V. SORENSEN STATED A CLAIM FOR INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS.

A plaintiff is entitled to damages for intentional infliction of emotional distress where the defendant intentionally engaged in some conduct toward the plaintiff (a) with the purpose of inflicting emotional distress, or (b) where any reasonable person would have known that such would result; and his actions are of such a nature as to be

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[9] Apart from opposing counsel, the client and expert witnesses, communications with at least two other individuals within opposing counsel's firm are mentioned in Barbuto's records. (*E.g.,* Addendum Exh. 3, Bates 19, 124). Even under Rule 9, specificity requirements are relaxed if the circumstances are such that the plaintiff cannot be expected to have personal knowledge of the facts constituting the wrongdoing. *Arena Land & Investment Co. v. McGee*, 906 F.Supp. 1470, 1476 (D.Utah 1994). A privacy claim is not subject to heightened pleading requirements, but the same principle should apply. If it is reasonable to believe that further disclosures occurred – almost a certainty in a case like this – the plaintiff should be able to discover that information. If it turns out that, contrary to expectation, no such disclosures occurred, the matter can be resolved through voluntary dismissal or summary judgment.

considered outrageous and intolerable in that they offend against the generally accepted standards of decency and morality. *Schuurman v. Shingleton*, 2001 UT 52, ¶ 10, 26 P.3d 227, citing *Samms v. Eccles*, 11 Utah 2d 289, 293, 358 P.2d 244, 247 (1961), citing *Restatement (Second) of Torts* § 46.

In this case, Barbuto argued that, as a matter of law, his conduct cannot be considered outrageous because its lawfulness was "fairly debatable" under Utah law. (R. 25-26). This suggestion cannot withstand the allegations themselves, which include that Barbuto, voluntarily and in furtherance of a personal agenda, made false statements regarding his patient to a third party to enable that party to gain an advantage over his patient, and accepted compensation from that party to reverse his prior opinions and records. That is not "fairly debatable" conduct for a physician. *See, e.g.,* AMA E-Principles, E -9.04 (1994) ("incompetence, corruption, or dishonest or unethical conduct on the part of members of the medical profession is reprehensible").

Whether particular conduct of a defendant was outrageous or intolerable is a question of fact for the jury. *Jackson v. Brown*, 904 P.2d 685, 688 (Utah 1995) (whether promise by already married man to marry plaintiff was outrageous was question for the jury). Significantly, the *Jackson* court recognized that, while "the mere decision to withdraw from a planned marriage is an insufficient basis for this cause of action," it became actionable if the defendant "acted with the intention of deceiving Jackson and with the knowledge that his actions would cause emotional distress." *Id.* Likewise, while the disclosure of confidential medical information might in some instances be insufficient to sustain a claim for intentional infliction of emotional distress, a jury question is

presented when evidence exists that such disclosure was done *sub rosa* and for the purpose of furthering the physician's personal agenda.

VI. THE TRIAL COURT ERRED IN DISMISSING PLAINTIFF'S NEGLIGENCE CLAIMS.

In the court below, Barbuto offered, and the trial court adopted, "as a threshold issue" that the allegation of intentional disclosure precluded a negligence claim. (CR. (R. 27 ("Plaintiffs don't shed any light on how a general negligence claim can arise from allegedly intentional tortuous [sic] conduct.")

While Barbuto might have been uncertain as to how allegations of negligent and intentional misconduct can co-exist, this Court and the Utah Supreme Court have made it clear on several occasions. In *Matheson v. Pearson*, 619 P.2d 321 (Utah 1980), for example, it was undisputed that the defendant's actions were intentional, in that he fully intended to throw a tootsie pop and to hit plaintiff with it. The defendant denied, however, that he intended to harm the plaintiff. *Id.* at 322.

The defendant filed a motion for summary judgment, arguing that, because the defendant intended his actions, the actions must constitute assault and battery as a matter of law, and therefore were governed by the 1-year statute of limitations instead of the ordinary 4-year personal injury statute. The trial court granted summary judgment, but the Utah Supreme Court reversed, observing:

> An individual may undertake an intentional act, such as throwing the tootsie pop in this particular case, and if the act is undertaken without an intent to harm or a substantial certainty that harm will result from the act, the actor is not guilty of an intentional tort. Instead, in such a situation, the activity is properly classified as reckless disregard of safety or reckless misconduct.

Id. at 322. "It is this absence of intent to harm which renders reckless misconduct or reckless disregard of safety a form of negligence and not an intentional tort," the court observed. *Id.* at 323. Accordingly, the court reversed and remanded for trial.

In *Doe v. Doe*, 878 P.2d 1161 (Utah App. 1994), this Court likewise reversed a summary judgment that had been granted upon a theory that a negligence claim could not be pursued because the defendant's sexual acts were intentional. "An individual's acts can simultaneously give rise to a claim for negligence and a claim for an intentional tort," the court said. *Id.* at 1162. "The two doctrines are not necessarily mutually exclusive, but rather may overlap and coexist on a continuum." *Id.* at 1162-1163.

In reversing the summary judgment, the Court concluded, "the trial court appears to have misunderstood this continuum in holding that defendant's actions could not, as a matter of law, constitute negligence since they were intentional." *Id.* at 1163. The court observed that it was bound by the recognition in *Matheson*, *supra*, that "reckless misconduct is a form of negligence and is distinguishable from an intentional tort." *Id.*; *see also* 57A *Am.Jur.2d Negligence* § 276 ("An individual may undertake an intentional act, and if the act is undertaken without an intent to harm or a substantial certainty that harm will result from the act, the actor is not guilty of an intentional tort").

It is possible for an intentional disclosure to be negligently made. (And a plaintiff is permitted to allege so in the alternative. U.R.Civ.P. 8(e)(2)). For example, Barbuto claimed below that he did not know that his conduct was unlawful. If the fact finder believes him, it might still conclude that he was negligent for making no effort to determine its legality, for falling below the standard of care in disclosing the information,

for failing to recognize the scope of his fiduciary duties, for placing his interests above those of his former patient, and so forth.

VII. THE TRIAL COURT ERRED IN RULING THAT SORENSEN HAD FAILED TO PLEAD DAMAGES ADEQUATELY.

As noted previously, for purposes of evaluating a motion to dismiss, the facts alleged in the complaint are considered true, with all reasonable inferences drawn in favor of the plaintiff's claims. Sorensen alleged in his complaint that he suffered economic and general damages. (R. 7, 9, ¶¶ 19, 35).

Barbuto argues, however, that because Sorensen was successful in filing an emergency motion in limine in the underlying case preventing Barbuto from testifying as to his modified diagnosis, no harm resulted from his breach of duty. The fact that Sorensen was able to partially alleviate the harm done by Barbuto's betrayal of his fiduciary duties and breach of confidentiality does not eliminate other harm already done. *See, e.g., Campbell v. State Farm Mutual Automobile Ins. Co.*, 840 P.2d 130, 139-140 (Utah App. 1992) (defendant's eventual payment of excess judgment entered against the plaintiff as a result of its misconduct reduced damages, but did not eliminate claim for general damages).

By its very nature, the violation of a patient's trust can be expected to cause emotional distress and other general damages. *See* Elder, *Privacy Torts* § 5.2 (delineating wide range of general damages recoverable for breach of confidentiality); *see also Machan v. Unum Life Insurance Company of America*, 2005 UT 37, ¶¶ 12, 16, 19 n. 2, 30, 116 P.3d 342 (nature of insurance contract is to provide peace of mind, therefore,

plaintiff's damages may include emotional distress). In addition to general damages, Sorensen also alleged economic damages, including additional legal fees and costs (*e.g.*, having to take a deposition of Barbuto to explore his improper activities), and an entitlement to punitive damages. Sorensen's damages were sufficiently pled, and the trial court erred by adopting Barbuto's argument and dismissing the complaint. [10]

CONCLUSION

For the reasons set forth above, appellants respectfully request the Court to reverse the judgment of the district court.

RESPECTFULLY SUBMITTED this 22nd day of August, 2005.

CHRISTENSEN & JENSEN, P.C.

L. Rich Humpherys
Karra J. Porter
Attorneys for Plaintiffs/Appellants

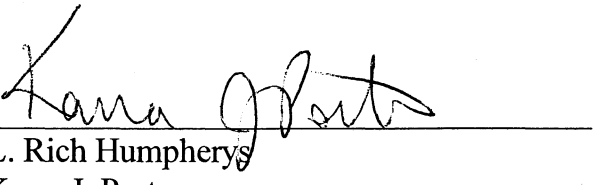
[10] Even if a fact finder determined that specific damages could not be established for Barbuto's breach of duty, the law recognizes equitable remedies in such a situation. *E.g., Snepp v. United States*, 444 U.S. 507, 100 S.Ct. 763 (1980) (where government could not establish damages from defendant's breach of confidentiality, constructive trust on defendant's monetary gain would be imposed). Sorensen's complaint includes a prayer for equitable relief. (R. 10).

CERTIFICATE OF SERVICE

This is to certify that on the 22nd day of August, 2005, two true and correct copies of the foregoing BRIEF OF APPELLANTS were mailed, postage prepaid, to:

Dennis C. Ferguson
WILLIAMS & HUNT
257 East 200 South, Suite 500
P.O. Box 45678
Salt Lake City, Utah 84145-5678
Attorneys for Defendants/Appellees

CHRISTENSEN & JENSEN, P.C.



L. Rich Humpherys
Karra J. Porter
Attorneys for Plaintiffs/Appellants

Exhibit 1

IN THE DISTRICT COURT OF THE THIRD JUDICIAL DISTRICT

IN AND FOR SALT LAKE COUNTY, STATE OF UTAH

NICHOLAS SORENSEN; KEVIN and PAMELA SORENSEN, limited guardians and conservators of Nicholas Sorensen,	:	MINUTE ENTRY
	:	CASE NO. 040916294
Plaintiffs,	:	
vs.	:	
JOHN P. BARBUTO, individually, JOHN P. BARBUTO, M.D., P.C., dba NEUROLOGY IN FOCUS,	:	
Defendants.	:	

Defendants' Motion to Dismiss was taken under advisement by the Court after the submission of Memoranda and oral argument by counsel. After further review and consideration, the Court rules as follows.

1. Defendants' Motion to Dismiss is granted in full as prayed for. By this reference, the Court incorporates herein all of the legal analyses and authorities set forth in defendants' Memoranda in support and reply, including that DeBry v. Goates, 999 P.2d 582 (Utah App. 2000), has no application to the present case because its facts are highly distinguishable.

2. Counsel for defendants is instructed to submit an Order consistent with this Minute Entry and Rule 7, Utah Rules of Civil Procedure.

Dated this 3 day of May, 2005.

TYRONE E. MEDLEY
DISTRICT COURT JUDGE

THIRD DISTRICT COURT SALT LAKE CITY STATE OF UTAH

MAILING CERTIFICATE

I hereby certify that I mailed a true and correct copy of the foregoing Minute Entry, to the following, this 3 day of May, 2005:

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Salt Lake City, Utah 84144

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Exhibit 2

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IN THE THIRD DISTRICT COURT FOR SALT LAKE COUNTY

STATE OF UTAH

NICHOLAS SORENSEN; KEVIN and PAMELA SORENSEN, limited guardians and conservators of Nicholas Sorensen, Plaintiffs, v. JOHN P. BARBUTO, individually; JOHN P. BARBUTO, M.D., P.C., dba NEUROLOGY IN FOCUS, Defendants.	**ORDER GRANTING DEFENDANTS' MOTION TO DISMISS** Civil No. 040916294 Judge Tyrone E. Medley

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This matter comes before the Court pursuant to a Motion to Dismiss filed by Defendants (hereafter "Dr. Barbuto"). The Court has reviewed the written memoranda and the legal authorities cited therein filed by Dr. Barbuto and Plaintiffs, and has heard and considered the oral argument of counsel. In considering the Motion to Dismiss, the Court accepts as true the factual allegations set forth in Plaintiffs' Complaint, which include the following material facts:

1. Nicholas Sorensen ("Mr. Sorensen") was injured in an automobile accident on July 24, 1999. (Complaint, ¶ 5.)

2. For the next year and a half (which means until approximately February 2001), Dr. Barbuto treated Mr. Sorensen for his neurological symptoms. After approximately February 2001, Nicholas Sorensen's neurologic care was transferred to Michael Goldstein and Western Neurological Associates. (Complaint, ¶ 6.)

3. Mr. Sorensen filed a legal action against Jack W. Marcelis and others seeking monetary damages for personal injuries received in the July 1999 accident. This legal action was resolved by trial in October 2003, resulting in a verdict in favor of Nicholas Sorensen. (Complaint, ¶ 7.)

4. Defendant's medical records, including those from Dr. Barbuto, were "produced and were made part of the stipulated evidence at trial." (Complaint, ¶ 8.)

5. After Mr. Marcelis's defense counsel subpoenaed Dr. Barbuto to testify at trial, Mr. Sorensen's counsel in that action and counsel in this action, L. Rich Humpherys, took Dr. Barbuto's deposition. (Complaint, ¶ 8.)

6. During the course of his deposition, it was disclosed that Dr. Barbuto had reviewed additional medical records sent to him by Mr. Marcelis's defense lawyer, had offered expert opinions as to the cause of Mr. Sorensen's neurologic symptoms, and had agreed to testify at trial regarding the cause of Mr. Sorensen's symptoms. Plaintiffs allege

in this Complaint that Dr. Barbuto's expert opinion that was to be offered at trial differed from the diagnostic statements set forth in his medical records. (Complaint, ¶ 10.)

7. Claiming surprise, because Dr. Barbuto's involvement had not previously been disclosed by counsel for Mr. Marcelis, Mr. Sorensen's attorney sought and obtained an order excluding Dr. Barbuto from testifying at trial.

Based upon these facts, Plaintiffs assert theories of legal liability against Dr. Barbuto based upon "breach of the covenant of good faith and fair dealing" (First Cause of Action), "breach of professional standards and statutes" (Second Cause of Action), "invasion of privacy" (Third Cause of Action), "intentional infliction of emotional distress" (Fourth Cause of Action), and "negligence" (Fifth Cause of Action). Plaintiffs do not allege the medical care provided by Dr. Barbuto to Mr. Sorensen following his injuries in the automobile accident of July 24, 1999 through February of 2001, when Mr. Sorensen began treatment with a different neurologist, was negligent. Rather, Plaintiffs claim that Dr. Barbuto's liability arises solely out of his examination of medical records generated by other health care providers after February of 2001, and *ex parte* communications with and opinions rendered regarding the cause or causes of Mr. Sorensen's symptoms to counsel defending the personal injury action. The factual and legal underpinning of all of Plaintiffs' claims is the allegation that Dr. Barbuto breached a duty of physician-patient

confidentiality by providing expert opinions on the cause of Mr. Sorensen's medical symptoms to counsel defending the personal injury claim brought by Mr. Sorensen.

Based upon the facts alleged by Plaintiffs, the Court finds that Plaintiffs' Complaint fails to state a claim upon which relief can be granted. Plaintiffs' claims alleging a breach of a duty of good faith and fair dealing fail to state a claim because there is no underlying contractual relationship between Plaintiffs and Defendants to which a duty of good faith and fair dealing attaches. Plaintiffs' claim that there was an improper disclosure by Dr. Barbuto of confidential physician-patient information fails because Mr. Sorensen's medical condition and the medical records relating to it were placed at issue in the underlying personal injury action, and Dr. Barbuto was privileged by statute and Utah State Bar Ethics Advisory Opinion Committee, Opinion No. 99-03 to speak *ex parte* with counsel. This case is clearly distinguishable from the case of DeBry v. Goates, 2000 UT App. 58, 999 P.2d 582 because, among other things, Dr. Goates disclosed confidential psychiatric information during a continuing physician-patient relationship, which disclosure was a *de novo* disclosure of confidential records. Neither does Plaintiffs' citation to American Medical Association Principles of Medical Ethics or Rule 506, Utah Rules of Evidence create legal duties upon which a private right of action can be based. Similarly, there is no private cause of action for alleged violations of the Health Insurance Portability and Accountability Act. Plaintiffs' invasion of privacy claims fail because Dr. Barbuto did not

publically disclose private facts. Indeed, Utah law permitted disclosure and discussion of Mr. Sorensen's medical records, which were necessarily part of his personal injury claim.

Additionally, the Complaint fails to allege a legal claim for intentional infliction of emotional distress or to state a claim for negligence arising out of the physician-patient relationship.

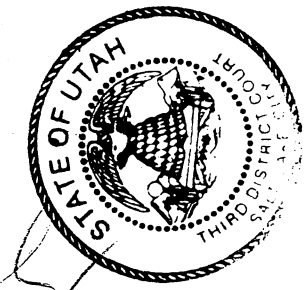
Finally, Plaintiffs have failed to demonstrate damages which could support a claim. Dr. Barbuto did not testify at Mr. Sorensen's trial and Plaintiffs have not alleged that Mr. Sorensen received any psychological evaluation or treatment for the alleged emotional distress, that Mr. Sorensen needed mental health counseling, that he suffered physical pain, that he suffered loss of employment or any other tangible injury associated distinctly with the claims against Dr. Barbuto. In the context of this case, allegations of distress and painful emotions, without tangible injury, are insufficient to support a claim for damages.

For these reasons and for all other reasons set forth in Dr. Barbuto's supporting memoranda, the Court hereby

ORDERS, ADJUDGES AND DECREES that Plaintiffs' Complaint and all claims asserted therein be and the same are hereby dismissed with prejudice. Each of the parties shall bear its respective costs and attorney's fees incurred to date.

DATED this 17 day of May, 2005.

BY THE COURT



TYRONE E. MEDLEY
District Court Judge

APPROVED AS TO FORM:

L. Rich Humpherys

121201.1

11 R

Exhibit 3

L. Rich Humpherys, 1582
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IN THE THIRD JUDICIAL DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

NICHOLAS SORENSEN, Plaintiff, vs. JACK W. MARCELIS, MICHELLE MARCELIS and SEAN MARCELIS, Defendants.	Civil No. 000905711 Judge William B. Bohling **MEMORANDUM IN SUPPORT OF MOTION IN LIMINE RE: DR. JOHN P. BARBUTO**

SYNOPSIS

After a serious accident on July 24, 1999, resulting in the death of one person and the extensive injury to the plaintiff, plaintiff's treating physician referred plaintiff to Dr. John Barbuto, neurologist, because of seizures from a brain injury. Dr. Barbuto's treatment began August 4, 1999 and ended early 2001, and largely dealt with prescribing anti-seizure medication and monitoring any seizure activity. The plaintiff changed to a different treating neurologist when Dr. Barbuto was no longer on the approved medical list for medical insurance purposes.

Dr. Barbuto's records were subpoenaed and have been disclosed. However, his deposition was not taken though Defendants subpoenaed Dr. Barbuto to be a witness at trial. Defendants have never disclosed at any time that Dr. Barbuto was involved as anything more than a fact witness. Totally unbeknown to plaintiff's counsel, defense counsel has been meeting with Dr. Barbuto ex parte without a HIPAA or any other release, and has retained him for purposes of reviewing extensive information and documents in order to render expert opinions at trial.

Plaintiff's counsel first became suspicious on September 17, 2003, during a deposition of the defense expert, Dr. Weight, when defense counsel produced a new document from Dr. Barbuto's file. Still, defense counsel failed to disclose the extensive ex parte involvement with Dr. Barbuto even though plaintiff's counsel specifically inquired about it. Based on this suspicion, plaintiff's counsel met with Dr. Barbuto on September 25, 2003 and for the first time learned of defense counsel's extensive ex parte contact and retention of Dr. Barbuto. Because Dr. Barbuto and defense counsel have engaged in illegal ex parte contact (without a HIPAA release), because Dr. Barbuto openly caters to the defense bar and has an extreme defense bias, and because plaintiff has just discovered that Dr. Barbuto has changed his medical opinions from those contained in his medical records and has formed even new opinions in areas outside of his original treatment, plaintiff brings this motion in limine to exclude his testimony.

STATEMENT OF FACTS

1. On September 11, 2003, defense counsel sent two releases to plaintiff's counsel and requested that plaintiff, Nicholas Sorensen, sign the releases, which would release medical information directly to defendants' counsel. See copy of defendants' proposed releases, marked as Exhibit 1 to the accompanying Affidavit of L. Rich Humpherys.

2. Shortly after receiving defendants' request, plaintiff's counsel responded that plaintiff's counsel had a policy of not giving general releases to opposing counsel, because of the unfortunate experience of having some defense counsel attempt without notice to use the release for ex parte contact with plaintiff's treating physicians. Plaintiff's counsel offered to obtain any records defendants desired and would produce them, or defense counsel could simply subpoena the records. See ¶¶ 1 and 2 of Affidavit.

3. At no time has defense counsel attempted to take the deposition of Dr. Barbuto, nor has defense counsel ever given any notice that defendants intended to call Dr. Barbuto as an expert witness for the defense, but instead to only be a fact witness regarding his treatment of the plaintiff. Dr. Barbuto's records were obtained more than two years ago and submitted to opposing counsel and both counsel had stipulated to their admission as part of the total medical record exhibit. At no time did plaintiff ever suspect defense counsel of having made ex parte contact with Dr. Barbuto, for the purpose of providing him with new documents and information and requesting him to render expert opinions for the defense. Id. ¶ 3.

4. On September 17, 2003, at the commencement of the deposition of Dr. David Weight (defendants' expert neuropsychologist), Tim Dunn produced a sheet of paper, which he

represented to be a photocopy of a page from Dr. Barbuto's file. Plaintiff's counsel asked if this was something in addition to the medical records that had already been produced. He indicated he thought it was. Plaintiff's counsel asked when and how Mr. Dunn got the document and he indicated that his associate, Steve Alderman had obtained it the day before from Dr. Barbuto's file. Plaintiff's counsel asked why Mr. Alderman was going through plaintiff's treating physician doctor's file without notice to us. Mr. Dunn indicated that they had a subpoena. Plaintiff's counsel stated that he had not received any notice of a subpoena, except for trial, nor any indication that opposing counsel would be going to Dr. Barbuto's office. Plaintiff's counsel then asked whether Mr. Dunn was hiring Dr. Barbuto as defendants' expert. Without denying it, Mr. Dunn simply stated he was paying for Dr. Barbuto's professional time, as he would with any professional. Plaintiff's counsel then asked if Mr. Dunn or his associates had personally met with Dr. Barbuto. Mr. Dunn indicated he was not sure what Mr. Alderman had done. Plaintiff's counsel then expressed that it would be highly inappropriate for opposing counsel to meet with plaintiff's treating physicians and eliciting expert opinions, without any notice to plaintiff's counsel. Mr. Dunn simply shrugged his shoulders, implying that he wasn't sure what was going on. Id. ¶ 4.

5. Even though plaintiff's counsel had directly addressed this issue with Mr. Dunn, at no time thereafter did defense counsel ever disclose that anyone had met with Dr. Barbuto (other than to get a copy of the one page from Dr. Barbuto's file) or that defense counsel had provided Dr. Barbuto with information or that he was going to elicit expert opinions from Dr. Barbuto based on the information defense counsel had provided to him. Id. ¶ 5.

6. After the deposition of Dr. Weight, plaintiff's counsel became more suspicious of what contact had been made with Dr. Barbuto and what Mr. Dunn intended to do when he called Dr. Barbuto at trial. Accordingly, plaintiff's counsel made an appointment with Dr. Barbuto and met with him on Thursday, September 25, 2003. When Julie Eriksson, a paralegal, and plaintiff's counsel sat down with Dr. Barbuto, without inquiry from plaintiff's counsel, Dr. Barbuto immediately began to explain that he wanted the record clear, he had met and talked with opposing counsel, had received extensive medical records from the office and had been asked to address certain questions, and was being paid by Mr. Dunn's office for his time. Plaintiff's counsel asked Dr. Barbuto if he had been retained as an expert. He answered that he had and he was responding to opposing counsel's request that he review the extensive medical records and render various opinions based on this review, the same kind of thing that he does in other cases when he is hired as an expert, except he had not seen plaintiff since his treatment. He also stated that opposing counsel had told him that opposing counsel was not going to refer to him as an "expert." He didn't understand this, but he professed that he didn't understand a lot about the legal profession. Id. ¶ 6.

7. Dr. Barbuto then began to explain that after meeting with defense counsel and reviewing additional information, he was changing his opinions that he had reached while treating the plaintiff. His conclusion while treating plaintiff and when contemporaneously reporting to Dr. Vogeler (plaintiff's primary treating and referring doctor) was that the seizures plaintiff had had after the accident were the result of the brain injury. Now, while not treating plaintiff nor reporting to Dr. Vogeler, he concludes that the seizures were a result of a preexisting

psychiatric and social (secondary gain) disorder. He readily admitted that his treating records and his course of treatment reflected the conclusion that the seizure activity was as a result of the brain injury, however, he was now changing his opinion. Id. ¶ 7.

8. During this conversation with Dr. Barbuto, plaintiff's counsel asked if he had prepared a report outlining his changed opinions. Dr. Barbuto indicated that he had prepared an extensive report (holding it in his hand) but that when he contacted Mr. Dunn's office and explained his opinions, he was told, for reasons he didn't understand, not to send his report to opposing counsel. Plaintiff's counsel asked to see the report. He refused, indicating that it was attorney work product, and that plaintiff's counsel would have to obtain permission from Mr. Dunn. Plaintiff's counsel reminded him that he was a treating physician and that plaintiff's counsel was representing his patient. Dr. Barbuto quickly responded that plaintiff was his patient and that presently he has no patient relationship with plaintiff. Plaintiff's counsel then asked if he had prepared anything else pursuant to the request of Mr. Dunn's office. Dr. Barbuto stated that he had prepared numerous pages of notes, but again, he would not allow plaintiff's counsel to see them without Mr. Dunn's approval, claiming that it was attorney work product. Id. ¶ 8.

9. Over the years plaintiff's counsel has had numerous experiences with Dr. Barbuto. In all situations Dr. Barbuto was involved in testifying in behalf of the defense and his testimony is almost always the same—that secondary gain and other unrelated conditions are mostly, if not completely, the cause of any current problems, assuming the problems are real. Id. ¶ 9.

10. In one of the last cases with plaintiff's counsel, Dr. Barbuto performed an independent medical examination (IME) of plaintiff Melia Fidel before any litigation, and found that she had a permanent partial disability rating of approximately 5 to 10% due to injuries she sustained in her neck from an accident. Being unable to reach a settlement, Mrs. Fidel retained plaintiff's counsel (here) to pursue her personal injury claim. When Dr. Barbuto was deposed, he completely renounced his prior report and claimed that Mrs. Fidel had only a minor neck strain which should have resolved within a few weeks after the accident and that there was nothing wrong with her. See ¶ 9 of Affidavit.

11. At trial in the Fidel case, Dr. Barbuto demonstrated his extreme defense bias, testifying about how America's compensation system was to blame for not only Mrs. Fidel's complaints, but for most chronic syndromes in general, basing his conclusions upon studies that were allegedly done in foreign countries such as Greece and Lithuania where there are no compensation systems. After excusing the jury, Judge Timothy Hanson listened to Dr. Barbuto for a half hour as Dr. Barbuto explained his incredible and unfounded opinion that because there were fewer patients with chronic medical problems in Greece and Lithuania, and because these countries did not have a compensation system based on fault, therefore America's compensation system is to blame for not only Mrs. Fidel's chronic problems, but for nearly all patients with chronic problems. Understandably, Judge Hanson threw out all of this testimony. See copies of the pertinent part of the trial transcript, pp. 34-54, attached as Exhibit 2 to Affidavit; see also ¶ 9 of Affidavit.

12. Importantly, Dr. Barbuto has admitted that he annually performed on the average approximately 200 IME's for the defense, making approximately $300,000 per year, but only did one or two for the plaintiff's side, one being for his brother-in-law, an attorney who asked Dr. Barbuto to do an IME but Dr. Barbuto never testified because his opinions were against the plaintiff. Id. ¶ 10.

13. Dr. Barbuto is notorious for his strongly biased opinions that the pain and other problems resulting from any trauma at issue were not caused from the trauma but originated from some psychological or secondary gain origin. Plaintiff's counsel has seen compilations of scores and scores of his defense medical examinations which all say nearly the same thing. Dr. Barbuto seldom, if ever, recognizes the trauma as the cause of the chronic problems, and nearly always suggests conscious or unconscious feigning or malingering (secondary gain). Id. ¶ 11.

14. Dr. Barbuto has publicly expressed his outrage regarding plaintiff attorneys who try to establish his bias and has specifically denounced a seminar that Mr. Humpherys presented to the plaintiff's bar regarding Dr. Barbuto's bias and willingness to give extreme defense opinions to endear himself with the defense bar, the source of most of his income. See ¶ 12 of Affidavit.

15. Plaintiff took Dr. Barbuto's deposition yesterday (September 30, 2003). Dr. Barbuto confirmed:

a. That he had no release from plaintiff to discuss his medical treatment with opposing counsel. Rough draft of his deposition, pp. 75-77, attached as Exhibit 6.

b. That he had been asked on May 23, 2003 if defense counsel could retain him at $315 per hour to review information and render expert opinions. See letters between defense counsel and Dr. Barbuto, dated May 23, 2003, attached hereto as Exhibits 1, 2, and 3.

c. On August 1, 2003 (a day after discovery cut-off), defense counsel sent extensive records to Dr. Barbuto and provided other information, asking him to address various records, and concluded in the letter, "After you have a chance to review his records give me a call so we can discuss your opinions. There are several issues we would like you to address but we can talk about those when you call." See letter of August 1, 2003, attached as Exhibit 4.

d. On August 11, 2003, Dr. Barbuto prepared a ten page written report. He contacted defense counsel and discussed his report and the other issues raised by defense counsel. Defense counsel told him not to send his report to them. See Report of August 11, 2003, attached as Exhibit 5, and p. 71 of the rough draft of his deposition attached as Exhibit 6.

e. Dr. Barbuto met with defense counsel for a couple of hours on September 16, 2003 and discussed Dr. Barbuto's opinions at length. See Dr. Barbuto's billing statement, attached as Exhibit 7, and the rough draft of his deposition, p. 72, Exh. 6.

f. When plaintiff's counsel called toward the end of September to make an appointment with Dr. Barbuto, he immediately called defense counsel to tell them plaintiff's counsel was meeting with him, p. 73, Exh. 6.

g. Dr. Barbuto admits that he never tried to let plaintiff and plaintiff's counsel know of his involvement with defense counsel. See pp. 77-81, Exh. 6.

h. Dr. Barbuto freely admits that he has now changed his opinion as to the cause of plaintiff's seizures, and that his prior opinions created a "mythology" about the cause of the seizures. See p. 23, Exh. 6.

ARGUMENT

I. DR. BARBUTO'S TESTIMONY SHOULD BE EXCLUDED IN ITS ENTIRETY AND ONLY HIS MEDICAL RECORDS SHOULD BE ADMITTED INTO EVIDENCE.

Dr. Barbuto's proposed testimony is fundamentally flawed and results in irreparable prejudice and damage to plaintiff's case. Once Dr. Barbuto, a doctor widely known for catering to the defense bar and for his extreme defense bias, has been retained ex parte by defense counsel, his testimony as a treating physician is fundamentally flawed. Merely restricting his testimony to his historical treatment cannot overcome this flaw and prejudice. He cannot undo all of his ex parte contact or his review of large quantities of new information and the loyalty that is associated with being retained by defense counsel (as evidence in part by his refusal to provide plaintiff's counsel with his report, notes and other work product without defense counsel's

approval). Any explanation of his records will be colored now through the improper tainting by defendants' conduct.

Restricting Dr. Barbuto's testimony will be ineffective to avoid the prejudice. In fact, it will cause additional prejudice since such restriction will preclude plaintiff from being able to demonstrate Dr. Barbuto's extreme defense biases and his illegal ex parte contact with opposing counsel. Instead, defendants would be able to perpetrate the myth that Dr. Barbuto is simply a treating physician being fully candid and honest with the jury. This would result in the ultimate damage to plaintiff's case, and would preclude plaintiff from having any means to present the true picture.

The exclusion of his testimony is further warranted by defense counsel's failure to disclose the ex parte contact, failure to disclose Dr. Barbuto's report, and in fact, taking affirmative actions to avoid disclosure, contrary to Rule 26(a)(3)(4) and 26(e), Utah Rules of Civil Procedure. Rule 26, requiring disclosure, is based upon the fundamental concept that justice is best advanced by open disclosure between the parties, including expert opinions. This concept is even more true when the defense has surreptitiously retained plaintiff's treating physician. But for pure happenstance, plaintiff's counsel would have never known about all of this until Dr. Barbuto was on the witness stand.

Rule 37 (f), Utah Rules of Civil Procedure, provides the exclusion of the expert when proper disclosure is not made;

> If a party fails to disclose a witness, document or other material as required...that party shall not be permitted to use the witness, document or other material at any hearing unless the failure to disclose is harmless or the party shows good cause

> for the failure to disclose. In addition to or in lieu of this sanction, the court may order any other sanction, including payment of reasonable costs and attorney fees, any order permitted under subpart (b)(2)(A), (B) or (C) and informing the jury of the failure to disclose.

Id. (emphasis added). The Advisory Notes to Rule 26 on the subject state as follows:

> The rule changes are intended to simplify discovery and promote full disclosure of discoverable information.
>
> * * *
>
> If a party fails to comply with the disclosure rule, Rule 37(f) requires the court to prohibit the use of the witness or evidence at trial unless the failure was harmless or there is good cause for the failure.

Id. (emphasis added).

The facts clearly portray a situation where defense counsel was attempting to engage in trial by ambush, the very thing Rule 26 was designed to prevent. Moreover, this was not regarding a peripheral issue of small import. On the contrary, Dr. Barbuto's testimony goes to the very heart of plaintiff's damage case, i.e., that plaintiff's uncontested brain injury has resulted in little damage, and most, if not all, of the problems he is experiencing can be related to some psychiatric disorder that pre-existed the injury. Not even defendants' neuropsychologist, Dr. David Weight, supports the extreme position that Dr. Barbuto has now taken. Dr. Barbuto is even so bold as to discard his treating opinions which were reported to the referring physician and for which he billed the plaintiff.

Apart from the propriety of defense counsel's actions, Dr. Barbuto clearly violated the law in his ex parte communications with defense counsel. In the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"), health providers are expressly precluded from disclosing information about their patient unless such disclosure is "pursuant and in compliance with a consent that complies with § 164.506..." 45 CFR 164.502 (a)(1)(ii). The Act further states that a provider "may not use or disclose protected health information without an authorization that is valid under the section." 45 CFR 164.508. The Act gives specific requirements before any authorization to disclose such confidential information is valid. Id., § 164.508(c). Neither Dr. Barbuto nor defense counsel had any release, let alone a "HIPAA" release.

The Act has some exceptions to the requirement of a HIPAA release before disclosures, however, under those exceptions, which don't apply, disclosure is subject to a condition, "provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the disclosure in accordance with the applicable requirements of this section." 45 CFR 164.510. No notice was given by Dr. Barbuto or defense counsel of their use of this confidential information to either plaintiff, his guardians, or plaintiff's counsel.

The Act specifically addresses disclosure of the confidential information in judicial proceedings. Such disclosure is allowed by court order or

> in response to a subpoena, discovery request or other lawful process, that is not accompanied by an order of the court...if:

(A) the [provider] receives satisfactory assurance...from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) the [provider] receives satisfactory assurance...from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of (e)(1)(v) of this section.

45 CFR 164.112(e)(1)(ii).

The Act further gives other qualifications to the use of such protected information in judicial proceedings, all of which are conditioned upon notice to the patient. Defense counsel's ex parte contact with Dr. Barbuto has clearly violated HIPAA law, which is consistent with Rule 26, Utah Rules of Civil Procedure, requiring up front and forthright disclosures. Defense counsel made no effort to disclose the ex parte contact, together with their retention of Dr. Barbuto as a defense expert, even though plaintiff's attorney two weeks before trial had specifically asked about any ex parte contact. Except by pure happenstance, plaintiff's counsel would have never known about this ex parte involvement until trial when Dr. Barbuto would be testifying.

The waiver of any doctor/patient privilege does not justify this surreptitious ex parte involvement. The purpose of a privilege is to require the nondisclosure of privileged information when subpoenaed or otherwise required to testify. A waiver of a privilege does not constitute a waiver of all rights of privacy and confidentiality and the HIPAA laws, thus allowing a doctor to talk with anyone about his patient and to even hold himself out for hire against his patient. There

remains a common law right of privacy and confidentiality, which would require at least a court proceeding, such as a deposition, a subpoena, and proper notice to the patient and his attorney, before a doctor voluntarily and for hire, addresses his patient's medical affairs.

Apart from the issue of disclosure, Dr. Barbuto's new opinions were not formulated until this past summer, and his report was not even requested nor written until August 11, 2003, long after the discovery cut-off dates. In fact, at the pre-trial on May 23, 2003, the parties represented that there was only a little discovery left and the Court opened discovery for the limited purpose of allowing defendants to have an economic expert, whose report was to be filed by the end of June and to allow a third deposition of the plaintiff.

Having discovered all of this twelve days before trial, and deposing Dr. Barbuto one week before trial, does not resolve the severe prejudice to plaintiff. Dr. Barbuto refused to provide plaintiff's counsel with his reports and other work product regarding his retention by defense counsel until his deposition which gives plaintiff's counsel no time to prepare or be able to respond with appropriate medical testimony at trial. When added to the fact that plaintiff did not even discover this until approximately twelve days before trial, together with the calculated and conscious effort to surreptitiously and illegally build evidence through a treating physician who is a well-recognized defense biased doctor, requires the exclusion of his entire testimony. Since Dr. Barbuto's treating records, which contain Dr. Barbuto's numerous narrative reports, are fully available for use at trial, the exclusion of his testimony will result in no prejudice to the defendants, exclusion is the only appropriate remedy. Dr. Barbuto's numerous reports to

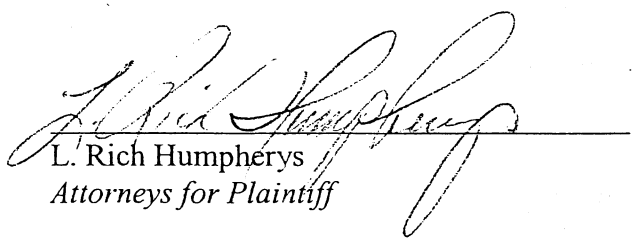
plaintiff's primary treating physician adequately sets forth Dr. Barbuto's opinions and treatment at the time.

CONCLUSION

The Court must exclude Dr. Barbuto's testimony in total. There is no other way to avoid the unjust and serious harm to plaintiff, and the unfair advantage to defendants. The relevant information about Dr. Barbuto's treatment and opinions is adequately evidenced through his medical records and reports.

DATED this 14th day of October, 2003.

CHRISTENSEN & JENSEN, P.C.



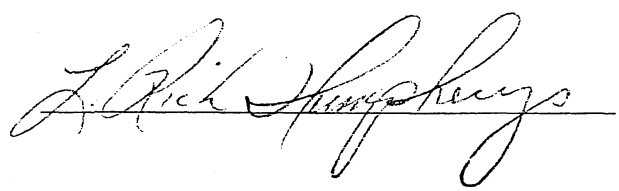
L. Rich Humpherys
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

This is to certify that on the 1st day of October, 2003, a true and correct copy of the foregoing **MEMORANDUM IN SUPPORT OF MOTION IN LIMINE RE: DR. JOHN P. BARBUTO** was sent by the method indicated below to the following:

Tim Dalton Dunn
DUNN & DUNN
460 Midtown Plaza
230 South 500 East
Salt Lake City, UT 84102

HAND DELIVERED



Neurology In Focus

An Outpatient Neurology Clinic at HealthSouth
John P. Barbuto, MD

8074 South 1300 East, Sandy, UT 84094
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Diagnostic evaluation, Neurological testing (EEG, EMG/NCV), and Therapeutic intervention

5/23/03

Kay Hanson, CLAS
Dunn & Dunn
Midtown Plaza, Suite 460
230 South 500 East
Salt Lake City, UT 84102

Re: Appearance at Sorsensen v. Marcelis trial

Dear Ms. Hanson,

We have received the notice of trial in the case of Nicholas Sorensen. As you know, there can be one "sticky" point which must be resolved prior to appearance. This is the issue of fees. I would like to presume that you expect to compensate me for my appearance at my normal fees ($315.00 per hour, including travel and court preparation). However, it is often unwise to make presumptions. So, I would like to clarify this. As you probably know, I see many patients with legal issues in the background. It is not possible to simply appear as a courtesy.

As you know, technically I can be commanded to appear as a witness of fact. The courts recognize that court appearance is a hardship and I have not personally experienced a situation where it was expected that the doctor would do this for free (or for the standard $18.50 service fee). However, the law does allow for such command appearance. As a witness of fact I could be commanded to appear; but then I would not prepare. I would not offer expert opinion. I would only restate what is in the records.

Alternatively, the usual situation is that appearance is as an expert. Such service would be charged as noted above.

Just to clarify the issue, please advise me which way you are asking for my appearance. Again, I wish I could simply make the presumption that you are proceeding under the usual procedure (appearance as an expert). However, I don't like to make presumption in issues of this type.

Sincerely,

John P. Barbuto, MD

DUNN & DUNN

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MARK A. RIEKHOF††
STEPHEN D. ALDERMAN •
STEPHANIE J. HOGGAN

May 23, 2003

VIA FACSIMILE (801) 565-6774

Dr. John Barbuto
Health South Rehabilitation Hospital
8074 South 1300 East
Sandy, UT 84070

Re: Sorensen v. Marcelis
Claim No.: 07A992060405
Our File No.: 00D-3860

Dear Dr. Barburto:

This letter comes in response to your letter dated May 23, 2003. [redacted] for your appearance at trial in the above referenced matter. In fact, we wonder if you would be willing to spend several hours (approximately 5) and review all of Nicholas Sorensen records. We would like to know what you think, as his treating physician early on in his injury, about his current condition. Let us know and we will see if our client will authorize something like that.

As you know, pursuant to our telephone call to your office yesterday, the trial that was scheduled to begin on May 28th has been continued. The trial is now scheduled for October (second place setting) or January, 2003 (first place setting). Accordingly, we will not need you to testify at this time. We will keep in touch with regard to when the next trial will begin.

Let us know if you would review Mr. Sorensen's records for us. If you have any questions, don't hesitate to contact me.

Yours truly,

DUNN & DUNN, P.C.

KAY D. HANSON, CLAS
Certified Legal Assistant

KH/

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5/23/03

Kay Hanson, CLAS
Dunn & Dunn
Midtown Plaza, Suite 460
230 South 500 East
Salt Lake City, UT 84102

Re: Appearance at Sorsensen v. Marcelis trial

Dear Ms. Hanson,

Thank you for your letter and clarification. Yes, I would be happy to review the rest of Mr. Sorensen's records and include this in the overall assessment of his illness. It is always a pleasure to see "the rest of the story" from which maximum insight may be obtained.

Sincerely,

John P. Barbuto, MD

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August 1, 2003

Dr. John Barbuto
Health South Rehabilitation Hospital
8074 South 1300 East
Sandy, UT 84070

Re: Sorensen v. Marcelis
Claim No.: 07A992060405
Our File No.: 00D-3860

Dear Dr. Barburto:

Enclosed please find copies of Nicholas Sorensen's medical records in the above referenced matter. You treated Mr. Sorensen following an automobile accident on July 24, 1999. [redacted] about a couple of things. The following is some information about what has been going on with Mr. Sorensen since you last saw him.

Mr. Sorensen received cognitive rehabilitation from HealthSouth until December of 1999. The last report from Eileen Paul, which was sent to you, indicated that he showed "significant improvement". Mr. Sorensen received no additional cognitive rehabilitation until February of 2003. During that period Mr. Sorensen started college and held down a full time job, successfully.

We have discovered that, prior to the accident of 07/24/99, Mr. Sorensen had a history of depression and uncontrolled temper. He also has a history of suicide threats, prior to the accident and since the accident. These suicide threats seem to be tied to breakups with girlfriends. You will also note that Dr. Bigler has recommended that Mr. Sorensen see a psychiatrist on several occasions and he has never seen a counselor of any kind except after he checked himself into the hospital because he felt like he was going to hurt himself and then only briefly.

Mr. Sorensen did receive a brain injury as a result of this accident. The question we have is to what degree his current issues are as a result of the injury and what those issues might be as a result of problems Mr. Sorensen had prior to the accident.

I have also enclosed a medical chronology of Mr. Sorensen's care. It is not complete, but it may be helpful in your review.

After you have a chance to review his records, give me a call so we can discuss your opinions about Mr. Sorensen's progress over the last several years. There are several issues we would like you to address but we can talk about those when you call.

If you have any questions, don't hesitate to contact me.

Yours truly,

DUNN & DUNN, P.C.

KAY D. HANSON, CLAS
Certified Legal Assistant

KH/
Enclosures

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8/11/03

Kay Hanson, CLAS
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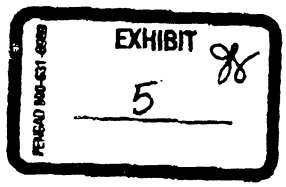

Re: Nicholas Sorensen

Dear Ms. Hanson,

I have performed an independent medical record review on Mr. Sorsensen at your request. While it is preferable to see the patient in person also, this is not always possible. Medical records are accepted as a representation of the patient's illness, and it is even recognized that details of the medical illness may be more accurately obtained from records than from the patient. Consequently, it is reasonable to evaluate the patient via the records. In the following review I have personally reviewed the records.

Medical Records Review:

DATE	PROVIDER	TYPE	NOTES
7/10/1997	Douglas Vogeler, MD	follow-up	patient seen for right knee pain attributed to twisting while mowing lawn. There is reference to "happened 2 years ago".
1/6/1998	Douglas Vogeler, MD	follow-up	patient seen for sinus congestion and headaches and depression.
2/25/1998	Douglas Vogeler, MD	follow-up	patient seen for report of smashed right hand 10/97 and smashed again 1/98. Also evaluated for right knee problems and referred to orthopedics
3/23/1998	Douglas Vogeler, MD	follow-up	continuing problems with depression
5/24/1998	Steve Hunt, MD	Lab	normal cervical spine series
5/24/1998	Steve Hunt, MD	Lab	normal CT brain scan
5/29/1998	Douglas Vogeler, MD	follow-up	reports he was jumped by a gang. Seen for headache and dizzines. Contusion found behind right ear. Reported to have concussion/contusion and depression.
7/22/1998	Douglas Vogeler, MD	follow-up	"still gets bad daily headache". Still moody. History of depression prior to accident.
9/8/1998	Douglas Vogeler, MD	follow-up	seen for reported 4-wheeler accident. Reports left arm and shoulder pain and numbness in 4th and 5th fingers.

7/24/1999	Tremonton City Ambulance	Evaluation	One car rollover. Found lying next to car. Bleeding. Transported. GCS 14/15 (a second report, also EMS, reported 13/15). Jaw pain and abrasion back of head, down back, left arm.
7/24/1999	Bear River Valley Hospital	Evaluation	Seen for accident. Noted to be confused. Abrasions of elbows, knee, chest, scalp.
7/24/1999	Bear River Valley Hospital	Lab	Chest x-ray: aspiration pneumonia and/or pulmonary contusion of right lung. Normal cervical and lumbosacral spine.
7/25/1999	McKay-Dee Hospital	Admission H&P	Patient reported to have been a roll-over accident in which he was ejected. He was found to have a closed head injury and transferred from another hospital. Exam shows nose abrasions, multiple chest abrasions, multiple ecchymoses of abdomen, bilateral abrasions to lower extremities. No spine problems noted. Labs showed bilateral frontal lobe contusions, left worse than right, right occipital fracture. Chest x-ray shows right pulmonary contusion. WBC 20.6. Many other tests done and basically normal.
7/25/1999	Christopher Penka, MD	Evaluation	Patient seen for neurosurgical evaluation of bilateral frontal contusions and skull fracture. Patient reports that he lost control of his vehicle. Exam: neurological noteable for GCS 15/15, retrograde and anterograde amnesia, other basically normal. Prior history of another concussive event one year prior.
7/26/1999	McKay-Dee Hospital	Discharge	Hospitalization revealed good improvement. Patient continued to complain of headache. Plan for transfer to Alta View Hospital.
7/26/1999	Nurse?	progress note	Patient apparently had "review" of potential for PTSD and advised to see Dr. Bigelow.
7/26/1999	John Sanders, MD	Admission H&P	Patient admitted for treatment. Reference to prior concussion one year prior "when a gang jumped him and beat him up". "He even had to change schools and went through some traumatic episodes with that." Exam notable for abrasions. Admit with diagnosis of cerebral concussion and bilateral contusions.
7/26/1999	John Sanders, MD	progress note	Patient noted to be awake, alert, cooperative, oriented and to have no motor or sensory deficits. DTR noted to be hyperactive but equal.
7/27/1999	Cottonwood Hospital:	Lab	CT brain scan shows multiple areas of increased attenuation primarily in the frontal lobes and felt to be most likely representing small parenchymal hemorrhages.
7/27/1999	Brenda Ross Zigich, CSW	Evaluation	Report of prior concussion with subsequent depression. Discussion of PTSD, concussion, and depression from current event
7/28/1999	John Sanders, MD	progress note	patient noted to be much improved and is discharged.
7/29/1999	Cottonwood Hospital:	Lab	MRI of right knee shows media suprapatellar plica but otherwise normal knee.
7/30/1999	Douglas Vogeler, MD	follow-up	seen for follow-up of mva with reported significant head trauma.
8/3/1999	Douglas Vogeler, MD	follow-up	reports pinching in right knee and low back pain with radiation down the right leg. Background depression and concussion also noted.

8/4/1999	John Barbuto, MD	Evaluation	patient seen for consultation for head injury. Noted to have had evidence for possible skull fracture and frontal contusion. Background depression noted. Exam basically normal at bedside. Felt to have concussion and contusion with unclear role of background depression.
8/13/1999	Eileen Paul, MD	Evaluation	Patient has speech/language pathology evaluation. He is noted to have some cognitive deficits primarily in learning and processing speed.
8/17/1999	John Barbuto, MD	Lab	EEG: "overall tense with some mild dysrhythmia and questionable left occipital slowing."
9/15/1999	John Barbuto, MD	follow-up	Patient presents reporting spells. No definite evidence of seizure activity, but also not excludable. Started on Depakote.
10/14/1999	Cottonwood Hospital:	Lab	Lumbar CT scan shows focal small central and right posterolateral Grade 2 L5-S1 disc herniation that abuts both S1 nerve roots, right greater than the left. Diffuse Grade 1 L4-5 disc bulge.
10/26/1999	Reed Fogg, MD	Evaluation	patient seen for his low back pain. He is said to have seizures and severe, disabling, back pain. Patient taking 4 psychoactive medications. Concluded to have "low back pain, rule out internal disc disruption, rule out chronic ligamentous and muscle injury."
10/26/1999	John Barbuto, MD	follow-up	patient reports cessation of his seizure-like spells since three days after starting Depakote.
11/4/1999	Cottonwood Hospital:	Lab	Lumbar MRI shows grade 2 central to right disc protrusion at L5-S1 and mild facet arthropathy at L4-5 and L5-S1.
11/16/1999	Reed Fogg, MD	follow-up	Scan findings are reviewed and it is concluded that the patient may have an internal disc disruption. Dr. Fogg advocates a conservative approach. Direct attribution to the auto accident is advocated.
12/10/1999	John Barbuto, MD	follow-up	"At some point we may wonder whether the Depakote is helping him because it is treating seizures or because it is treating a mood disorder. However, for the time being we will assume it is treating seizures."
12/16/1999	Cottonwood Physical Therapy	Evaluation	patient completes intake forms for physical therapy. Patient has a brief course of therapy.
12/20/1999	Eileen Paul, MD	follow-up	patient completes cognitive therapy (spanning from 8-13 to this date). Patient said to have had significant improvement in all areas.
3/9/2000	John Barbuto, MD	follow-up	Letter to patient regarding the status of his claims and plans. [See letter for details.]
3/20/2000	Kathy Alderson, MD	Lab	EEG normal.
4/26/2000	John Barbuto, MD	follow-up	"Two normal EEG's. Can't prove seizure."
6/20/2000	Cottonwood Hospital:	Lab	lumbar discography: L4-5 anatomically normal and no symptom production. L5-S1 injection produced his typical low back pain and annular cleft was observed with subligamentous extrusion.
8/2/2000	Terry Sawchuk, MD	Evaluation	Patient is seen for his reported back and leg complaints. Five page report. In conclusion, IDET is advocated.

12/1/2000	Erin Bigler, PhD	Evaluation	patient seen for neuropsychological evaluation. "Results of intellectual assessment indicate level of function to be within the average range. No specific intellectual deficit is noted." He is noted to have significant levels of depression and anxiety. He is felt to have "classic post-concussive syndrome" [except for the obvious issue that it is a year and a half after the concussion].
1/10/2001	Cottonwood Hospital:	Lab	EEG: low voltage fast pattern, some tension, one posterior spike noted.
2/27/2001	Michael Goldstein, MD	Evaluation	Patient seen for neurological evaluation. Noted to be a 19 year old full time college student at SLCC. Seen for evaluation of seizure disorder. Patient reports that "shortly after the accident Mr. Sorensen began experiencing partial seizures, which would occur approximately 8-10 times a day" [Note: this is not an accurate history. Patient had seen me in 1999 with no mention at all of seizures. Later there were only questions in this regard. See conclusions.] Report is 4 pages long. See for details. Based on what patient presents the history of seizures is presented as if established.
3/16/2001	Reed Fogg, MD	follow-up	In a letter to IHC Health Plans Dr. Fogg discusses that "I recognize there is still some question as to the validity of an IDET procedure. However, I believe that Nicholas Sorensen would be much better served with an IDET than an anterior interbody fusion."
3/21/2001	Michael Goldstein, MD	Lab	MRI of brain shows "findings are consistent with remote post traumatic changes. There are small hemorrhages and encephalomalacia at the frontal poles and left frontal convexity."
7/27/2001	Cottonwood Hospital:	Lab	Lumbar MRI: grade 1-2 posterior central disc protrusion.
8/17/2001	Terry Sawchuk, MD	Admission H&P	Patient admitted for treatment of lumbar herniated disc. Patient taking Depakote, Effexor, Trazodone, Celebrex. Admitted for IDET procedure, which occurs on this date.
9/14/2001	Cottonwood Physical Therapy	Evaluation	patient seen for another brief course of physical therapy.
1/23/2002	Michael Goldstein, MD	Lab	24 hour ambulatory EEG shows normal background activity. Patient reports various behavioral disturbances. Report concludes "normal 24 hour ambulatory EEG with no correlation between EEG and symptoms including 'shut down feeling'".
2/8/2002	Michael Goldstein, MD	follow-up	patient seen for tremor. He is felt to have an essential tremor, possibly aggravated by Effexor and Depakote.
2/22/2002	Gregory Dunnavant, MD	Evaluation	Patient seen for depression. He asserts that "nobody take my headaches seriously". He asserts that he is "stressed out" about life. Patient felt to have a mood disorder and psychiatric care is arranged.
2/27/2002	Michael Jorgensen, MD	Evaluation	Patient seen in ER for "complains of two personalities, feeling of losing control". Reportedly having suicidal thoughts. Reports chronic headaches in background. Also reports prior head trauma and seizures. Meds: Depakote, Effexor Trazodone, Paxil.
2/27/2002	George Nikopoulos, MD	Admission H&P	patient admitted for suicidal behavior. He is concluded to have major depression.

3/2/2002	George Nikopoulos, MD	Discharge	Patient discharged from LDS hospital where he was admitted for depression.
4/2/2002	David Weight, PhD	Evaluation	Neuropsychological evaluation. 15 page report. Overall patient's intellectual function is determined to be in the normal range. He is noted to have had objective injury in the index accident. And, he is noted to have had pre-accident depression.
5/30/2002	Michael Goldstein, MD	follow-up	patient seen for spells. "I reviewed the situation with Nicholas and his father. I explained to them the executive function deficits and impulse control problems he was having are related to his brain injury. I recommended that they keep in close contact with the psychiatrist and counselor to determine what medications would be best for this." [Considering the recommendation for psychiatric treatment and the prior psychiatric care how can one be sure this is injury and not psychiatric illness?]
2/14/2003	Kristin Lambert, M.ED	Evaluation	Patient is seen for speech-language pathology evaluation. Patient gives history of a 3.9 GPA in high school at A's and B's at SLCC. He claims reduced academic load due to fatigue. He obtained social dispensations for classwork. His various claims of symptoms and conditions are discussed. He has cognitive testing which is reported to show various deficits. [Note: the studies list his apparent state of function, but the report does not provide conclusions as to what caused that state of function (which, I would argue, is appropriate).]
4/10/2003	Douglas Vogeler, MD	lab	patient has Epstein-Barr titers which are high, both IgG and IgM.

Impressions and Conclusions:

Mr. Sorensen presents a particularly interesting and complicated situation. In the final analysis it is my opinion that his condition is best understood using a biopsychosocial model of analysis. And, all three elements (biological, psychological, and social) are seemingly quite important.

On 7/24/99 the patient was involved in an accident. In the review of the records of the event it is noted that the patient was involved in a single-car rollover. The patient asserts that the accident happened because the driver lost control of the car.

At first blush the initial perspective is that Nicholas was clearly injured in the accident. He was admitted to the hospital with bilateral frontal brain contusions, a probable lung contusion, and multiple abrasions. There is also a history of lumbar disc protrusion which does seem reasonably related to the accident.

The frontal brain contusions are unquestionably related to the accident. The brain contusions were followed initially by prompt improvement, in a fashion quite compatible with actual injury. Within days his clinical function was basically normal.

However, the long term story of his brain function requires a more complex analysis (as discussed below).

The lung contusion was also unquestionably related to the accident. This problem cleared quickly.

Multiple abrasions were also unquestionably related to the accident. However, these were basically minor, and also cleared quickly.

The lumbar disc protrusion is probably also related to the accident. The disc bulge was not dramatic. However, he was only 18 at the time and a lumbar disc bulge would be uncommon at that age. In addition, while not immediately, it was only a few days after the accident when he complained of the low back and right leg problems. Given the presence of the other, more critical, and obscuring, issues it seems prudent to disregard the fact that lumbar and right leg complaints were not immediate.

Therefore, the first perspective is that he was injured. I'll say more about this below.

Yet, the second perspective is that he has improved much more poorly than the degree of his objective findings would have predicted, particularly at his age. The failure to follow a normal graph of healing suggests that psychosocial factors may be at play. Indeed, he had an underlying depressive disorder. Further, much of his care subsequent to this accident has centered on subjective complaint and on clearly psychiatric issues. So, there is a second story which is his psychiatric story.

Third, there probably is a significant contribution from the social circumstances. Even in spite of his psychiatric history there are features which suggest that the social context is acting as a fomenting influence.

To me this patient is particularly fascinating because it appears that he has a mythology of purported seizures which I inadvertently set in motion. I saw the patient about 10 days after this accident. At that time he had no history suggesting any seizure activity. However, because of his documented contusion I thought it wise to do an EEG to see if there was any subclinical seizure activity. His EEG ended up showing some minor dysrhythmia, maybe of the type often seen in psychiatric patients (an interesting side discussion). When these results returned I told the patient about the results, and probably said something to the extent that the EEG was not exactly normal but did not look like seizures. At that moment I may have planted the seed. The patient then later returned with the "evolved" claim of spells. Given the claim and the presence of the prior contusion I had little choice but to proceed with the possibility of seizures and I prescribed Depakote. However, I noted at that time that there was no solid evidence of seizures. Reportedly due to insurance change, the patient stopped seeing me shortly thereafter. Now, years later, it becomes apparent that this beginning seemingly set in motion a mythology—the mythology that he has a seizure disorder. When he saw Dr. Goldstein in 2001 he then presented the history that he began experiencing partial seizures numerous times a day shortly after the

accident and that I had started him on Depakote as if seizures were confirmed. In spite of the patient's claim of spells up to many times a day, his subsequent EEG's (including an ambulatory 24 hour EEG) have not shown definitive epileptiform activity. He has continued Depakote but there has not been confirmation of the presence of seizures. Depakote is also used routinely in mood disorders. While the possibility of seizures most clearly exists in a patient who has had brain contusions. The actual presence of seizures has not been confirmed. In addition, the 24 hour ambulatory EEG commented directly on the lack of correlation between his claimed spells and any evidence for actual seizure discharge.

So the analysis of this young man requires, in my opinion, recognition of all three major components: biological, psychological, and social.[AB] In a situation of this type, with clear brain injury, the resolution of the contribution from the various components may become a daunting task. I do not claim to have a crystal ball. However, I'll do the best I can here to segregate the issues.

Let us consider the issue of brain injury first. There is no question that brain injury occurred. Further, there is no question that brain injury may have impact on psychological function. Therefore, reasonable consideration of a role for the accident in both structural issues and psychological issues is required. Based on the scan findings and his prompt improvement when hospitalized acutely it would be predicted that he would have good resolution of this component of his syndrome. (Indeed, that was my prediction when I first saw him only a few days after the event.) And, he did indeed improve promptly during the early course. However, lurking in the background were both psychological and social issues. Unfortunately, it appears these conspired to preclude the prompt resolution which his initial findings would have predicted. Note in this regard that later testing of his cognitive function showed dysfunctions which were non-specific, and of types which may easily be seen in depression and/or anxiety. Both Dr. Bigler and Dr. Weight, for example, found that his intellect was basically normal. Brain scans did reveal some residual findings, but these were not large. Similar degrees of abnormality may be found in patients with no clinical abnormalities.

He had underlying psychiatric illness and then he had frontal lobe injury. So, one question we must examine is the impact of frontal lobe injury on behavioral state. This can take us back to the famous case of Phineas Gage, who, via an unintended frontal lobotomy from brain penetration by a tamping rod, showed us the potentials for behavioral change which may occur from frontal lobe problems. To be sure, invoking such issues as directly pertinent to Mr. Sorensen would be hyperbole. However, the concept of behavior change from frontal lobe injury can be relevant. So, we then must ponder whether his frontal lobe injury was truly contributory to his later behavioral dysfunction. While the discussion can be lengthy, I would summarize that I don't think his degree of frontal lobe injury had any notable long term

behavioral consequence. Rather, it seems to me more probable that his behavioral problems were simply further manifestations of his underlying psychiatric illness.

Depressive disorders commonly begin to manifest in the late teenage years. Typically they progressively worsen during the 20's and 30's under the influence of increasing life stresses. From actual injury, particularly of the degree he suffered, suicidal ideation would be very anomalous. However, from depressive disorders this may develop. I think the clear issues of suicidal ideation stand as additional support that his behavioral disturbance was a mood disorder rather than a frontal lobe brain injury consequence.

Summarizing, I think he did have a brain injury and short term it was clearly an issue. However, long term it appears his depressive disorder is much more relevant to his behavioral and cognitive issues.

The next issue is the question of seizures. This is largely discussed above. To summarize, I don't think time and subsequent testing has confirmed any seizure disorder.

The next issue is the lung contusion. This resolved promptly.

The next issue is the multiple abrasions. These also resolved promptly.

The next issue is the lumbar disc disease. I do think this needs to be related to the auto accident. However, we do have a confounding factor. Many, many patients with chronic stress biology will manifest back pain complaints which are ultimately a derivative primarily of chronic stress-induced muscle spasm. Not only does this mean that the mechanisms involved may be mixed issues (disc plus spasm, for instance) but it also means that persisting problems may be more related to the stress than to the disc. Further, patients with primarily stress mechanisms tend to fail surgery (when someone does this chasing a modest disc bulge). In the case of Mr. Sorensen we note that his disc bulge was not dramatic. It does appear from the discogram that the bulged disc was a source for his pain. The records do not make it clear if his IDET worked or not. At this point I would suggest that the disc bulge, early back care, and the IDET should be related to the auto accident. However, if he did poorly after the IDET then we need to give consideration to recognizing that surgical failure and long term complaint may be related to his underlying stress and depressive illness rather than to the accident.

I believe the above answers the questions you posed.

Sincerely,

John P. Barbuto, MD

EndNotes:

[A] **The BioPsychoSocial Model of Analysis:**

The biopsychosocial model of analysis is particularly appropriate many poorly explained, yet chronic, syndromes, particularly those which are also poorly responsive to medical treatment. The model acknowledges the large and expanding body of literature identifying that biological elements, psychological elements, and social elements may all contribute importantly to such syndromes. Treatment failure is often best explained by recognition that social and psychological issues may make illness self-propagating, and claim of illness even advantageous. The biopsychosocial model was proposed by George Engel in 1977 as a replacement for the old "organic versus nonorganic" dichotomy which is routinely neither accurate nor sufficient as an analysis paradigm for complex syndromes of these types. There are now on the order of 1200 peer-reviewed articles referenced in Medline which discuss the subject from one perspective or another. Over 200 of these focus on chronic pain syndromes. In addition there are perhaps many times this many published editorials or other non-Medline discussions which reference this concept. The AMA Guides to the Evaluation of Permanent Impairment has also referenced this discussion in its consideration of chronic pain.

In the biopsychosocial syndrome it is typical for psychiatric or social mechanisms to be predominant. Yet, the patient may strongly deny these issues. The patient may become quite angry when such issues are discussed. Overstatement of a claim of injury, in particular, has become a route for these patients to serve many hidden social and psychiatric agendas.

Another issue common to the biopsychosocial syndrome is excessive support of an biological (particulary injury) hypothesis by providers or others who may stand to benefit from economic opportunities these patients provide. These patients, driven by their psychological issues and/or social needs, may volunteer for grossly excessive medical care and other services. A minor "fender-bender" for example, may be driven to an opportunity for many years of services. While most providers do not seek an inappropriate relationship to these patients, there are a small number of providers who may exploit these patients. Highly invested participants may become very vociferous in objection to discussion of the actual issues.

In the biopsychosocial syndrome the patient may ultimately become the victim the services provided. An objectively minor accident, for example, may be fostered into a multiyear illness—one in which there is grossly excessive medical care, poor response to treatment, iatrogenic worsening via excessive belief in illness and consequences of unnecessary invasive treatment. The biopsychosocial syndrome patient may become emotionally and physically more dysfunctional over time. The patient may ultimately become "a wreck"—not due to the original event, but due to the excessive utility of overstating the hypothesis of biological illness (particularly injury). The ultimate utility of understanding the biopsychosocial model is greatly more accurate and effective patient care.

[B] **The Need to Hypothesize:**

The court systems understandably prefer not to hypothesize. However, in the biopsychosocial patient hypothesis is basically unavoidable. Characteristically in these patients there is a large disparity between solidly objectively findings (for example, by the laboratory) versus symptom claims being made. Therefore, we may need to hypothesize what we think accounts for the disparity.

Commonly providers attempt to explain the biopsychosocial syndrome patient by some hypothesis which presumes an occult biological process. Labels such as "sprain", "strain", "soft tissue injury", or "post concussion syndrome" are often invoked. Yet, while such hypotheses might, at first blush, seem reasonable, the course of the illness reveals that the syndrome is excessive for any reasonable use of such terms. In the biopsychosocial patient it is common for minor versions of these processes to be present at the beginning of the syndrome, but as time proceeds these resolve and become replaced by psychosocial dynamics. Typically this transition occurs in the first few weeks of the claimed illness.

In some of these patients there are no objective findings. The entire claim of the illness proceeds on subjective complaints. In other patients minor injury is proven but it is minor, and not a reasonable explanation for the subsequent excessive syndrome. And, in a few there is clear and significant injury; yet, there is a subsequent syndrome which exceeds what even this would reasonably predict. We may, to a reasonable extent, allow ourselves to hypothesize some kind of injury mechanism; however, in these patients psychological or social mechanisms often provide a much more logical way to explain the disparity between major claims and minimal test findings.

Since we have a poor ability to test for stress illness, psychiatric illness, and hidden social agendas we have a limited ability to prove absolutely when these are present. Therefore, we have a limited ability to prove that these are the cause for the disparity between the patient's few abnormal tests and the extensive syndrome claimed. Yet, it is actually bias or prejudice to discount psychological or social mechanisms and presume injury. To do so may not only be inappropriate in resolution of social contingencies, it may also encourage the patient to remain ill and to receive ill-

conceived medical care. In these patients we may need to hypothesize which specific psychological or social issues are present (because the laboratory cannot confirm our hypothesis) but psychosocial dynamics routinely make far greater sense than an injury hypothesis.

IN THE THIRD JUDICIAL DISTRICT COURT

OF SALT LAKE COUNTY, STATE OF UTAH

-ooOoo-

NICHOLAS SORENSEN,	:	
	:	
Plaintiff,	:	DEPOSITION OF:
	:	
vs.	:	JOHN P. BARBUTO, MD
	:	
JACK W. MARCELIS, MICHELLE MARCELIS and SEAN MARCELIS,	:	Civil No. 000905711
	:	
Defendants.	:	(Judge Bohling)
	:	

-ooOoo-

BE IT REMEMBERED that on the 30th day of September, 2003, the deposition of JOHN P. BARBUTO, MD, produced as a witness herein at the instance of the plaintiff herein, in the above-entitled action now pending in the above-named court, was taken before JEANETTE LUND, a Certified Shorthand Reporter and Notary Public in and for the State of Utah, commencing at the hour of 3:15 p.m. of said day at the offices of Dr. Barbuto, 8074 South 1300 East, Sandy, Utah.

That said deposition was taken pursuant to notice.

A P P E A R A N C E S

For the Plaintiff: L. RICH HUMPHERYS
Christensen & Jensen
50 South Main Street
Suite 1500
Salt Lake City, UT 84144

For the Defendant: STEPHEN ALDERMAN
Dunn & Dunn
460 Midtown Plaza
Suite 460
Salt Lake City, UT 84102

I N D E X

E X H I B I T S

P R O C E E D I N G S

JOHN P. BARBUTO, MD,

called as a witness for and on behalf of the plaintiff, being first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. HUMPHERYS:

Q Would you state your full name, please?

A John Patrick Barbuto.

Q Your occupation?

A I'm a neurologist.

Q Did you have the occasion at one point in time to treat a patient by the name of Nicholas Sorensen?

A I did.

Q And what was the time period in which you treated him, beginning and ending date?

A I first saw Nicholas on August 4th of 1999 and the last visit appears to be 2/13/01.

Q Other than responding to subpoenas, did you have any further involvement with this case until May of 2003 when you were subpoenaed to go to trial and there was some communications with Dunn & Dunn?

A No.

Q Before we get into anything more, let me mark some exhibits and we can get those identified and

squared away before we move into the other areas.

MR. HUMPHERYS: Would you mark that as Exhibit 1, please.

(Whereupon, Exhibit No. 1 was marked for identification.)

Q Doctor, I'm going to show you what's been marked Exhibit 1. Just thumb through that and make sure these all appear to be records or copies of records from your file. Not that that is complete, but that everything in Exhibit 1 are records from your file.

MR. HUMPHERYS: Will you mark this as No. 2, please.

(Whereupon, Exhibit Nos. 2 through 5 were marked for identification.)

THE WITNESS: Yes, it appears these are all from my file. There are a few letters in here from insurance companies and things, and it looks like those are letters that were either to me or from my file, but without actually looking at those letters I can't tell they are actually my documents. I think they are, but I'm not sure of that. Most of the records are my records, and those clearly are from my file.

Q With the exception of the letters either to or from an insurance company?

A Yes, I think that's correct. There's a letter from Eileen Paul in there, that top one, which I know appears in my stuff someplace. And I think the rest of it, I can say for sure. It's only those ones where they're letters from insurance companies, and I don't know for sure they're in my file. I think they are because I gave you copies of my file the other day, so I think that's where you got them.

Q Let me show you what's been marked as Exhibit 2, which are copies of records we obtained from your file last Thursday when we met, I believe it was Thursday, and I just wanted to make sure those are also copies of records from your file.

A I think all of these are except there's one of them I don't recognize, which is a letter dated 1/5/99 from Nicholas Sorensen and it's to Safeco Insurance, and I don't -- that may be in my records, I just don't recognize it.

Q All right. Why don't you check, because I believe we got it from your records. I was going to ask you where you got it, because it didn't seem like it was a letter that concerns you or was addressed to you. It's towards the bottom of your file I believe.

A Let's go backwards, then. I'll go from the other end.

Q There it is.

A Here it is.

Yes, it is in my file.

Q Do you know where it came from?

A No. Let me see if I can tell by where it is.

Yes, it looks like this came with this letter here from Greg Hamblin from September 1st, 2000, from Allstate. There's a letter here from a Greg Hamblin who is a claims representative at Allstate, and it says -- do you want me to read it?

Q No, that's all right.

A It looks like that's where this came from.

Q Is that what it says or is that what you're assuming?

A It says here, "In a letter written by Nicholas regarding his claim, he mentions you are treating him for a brain injury and subsequent seizures." And then there is this letter that is dated 1/5/99 by the patient, and there is a highlighted portion of it that says, "Dr. Barbuto who has been treating me for my brain damage. After the accident I was having seizures and he put me on Depakote." So it looks like this was probably sent as an attachment ot the letter from a Greg Hamblin.

Q Okay. It doesn't look like it specifically

referred to, but there's some logical connection between the two?

A Yes, that's one of the reasons I looked at where they were in the chart. Basically as stuff comes in, more or less it just gets put in chronological order, although after these records get pulled out, they get copied, things can certainly get mixed up. But it just so happens it is in juxtapositioned to this letter, and the letter references that and that section of the letter that you're talking about is highlighted, so presumably that's where it came from.

Q All right. Fair enough.

Now I would like to show you what's been marked as Exhibit 3, which is a letter from Dunn & Dunn to you dated August 1st, 2003, and just have you confirm that that is also part of your records?

A Yes.

Q And Exhibit 4 is a billing that you provided me today. Is this a billing to Dunn & Dunn?

A Yes.

Q For your worked involved in this case?

A Yes.

Q Does this comprise all of the billings you have submitted to Dunn & Dunn?

A Yes.

Q And there's currently an outstanding balance of $787.50?

A Yes.

Q Do you anticipate doing any additional work for Dunn & Dunn or any additional billing?

A I suppose that depends upon what you guys do with this case. In other words, as you know, he did ask me to review the additional records, which are here, and then I did talk with him thereafter and that's reflected in the billing. And so if you guys are able to settle this thing, then the answer would be no. If that is not the case, then it is possible certainly that he would want to talk to me prior to trial, or you might even want to talk to me prior to trial, but certainly he may want to, and so I would presume that to be the case.

Also, when we had our conversation the other day I mentioned to you that if there were additional data, such as prolonged EEGs, other kinds of things that would provide further data regarding this question of seizures and spells and what these spells are, if there were additional data of that type, then that may be relevant in the file sort of assessment of where we think we are with this. And if you or he would gather that information, then presumably that would come into

discussion also.

Q But in terms of being requested to do anything more, you have no present direction in that regard?

A Correct -- I take that back.

THE WITNESS: You've asked me to show up at trial?

MR. ALDERMAN: Yes, we've sent you a subpoena.

THE WITNESS: So consequently I have had that, which is a request to appear at trial.

Q And, finally, Exhibit 5 appears to be a report dated August 11, 2003?

A Correct.

Q And it is ten pages long; is that correct?

A Correct.

Q Now, does your report of August 11, 2003, contain your current opinions?

A Yes, I believe it does. I believe there have been no additional data that has come in since that time, and so that contains the opinions I had as of the time I wrote it, yes.

Q Having just received this immediately before the deposition, I haven't had time to read it except for a couple few paragraphs. Help me understand the make up of your report. First paragraph obviously indicates the directions you were given to perform this

independent medical record review.

A Right.

Q And then the next section is simply your notes from the records that you have reviewed?

A Correct.

Q And you know of no other notes other than these typewritten notes that you have taken based on your record review?

A That's correct. You know, when we were starting here at the beginning you mentioned you thought you saw some handwritten notes. It isn't my usual character to handwrite because my handwriting is not that great and I usually just work at the computer. So I don't -- I'm not aware of any handwritten notes. This is where I would normally put all of my stuff.

Q And you would not keep any handwritten notes?

A I would never have generated them. In other words, they would be -- when I'm going through records, I actually have my computer set up and I'm sitting just as this young lady is here typing into the computer.

Q At the end you have end notes on pages 9 and 10.

A Yes.

Q Tell me what these are.

A Basically those are some sort of broad

discussions that are commonly relevant to these kinds of things. That actually was there just simply because it was in my form. This is a -- the basic document that I use to start with making my notes is a form, that form contains some places where I can put information such as the record review and I have one for when I do record reviews. In that the form contains, as I said, the basic structure, such as record review, impressions and conclusion, and there are some types of discussions such as the biopsychosocial model that come up recurrently, so I put those as footnotes and they are just in the form and they happen to, then -- they print at the end of the document.

In this case where those footnotes reference is in the second paragraph of page 7.

Q All right. And this is simply like the foot -- or is a footnote to those --

A To explain.

Q -- paragraphs on page 7?

A Right, some of these concepts and things.

Q Now, is this a biopsychosocial model analysis something that you generated as it relates to Nick or is this something that is generic?

A Well, I'm sorry, are we talking about the

model itself?

Q I'm talking about footnote A. Was this generated specifically as it related to this matter or was it generated in some generic form that you just copied and pasted?

A Right, that's just in the form as a generic thing about the biopsychosocial model, some of the background. That does not pertain specifically to Nick.

Q I see. And tell me where the source of this information came from.

A Well, I wrote it, and it is a sort of broad brush discussion of the biopsychosocial model and references some of the literature which is in the background for that, such as George Engel's stuff that was the original article in Science magazine and then some of the Medline references and that kind of thing that are discussed. And it talks about what are the elements of a biopsychosocial model and why do we use it. So it's a general perspective for people who are not familiar with the model.

Q Tell me what article George Engel's -- or publication came from?

A It appeared in Science in 1977, and I don't remember the exact title. It's something like

"Biopsychosocial Model, An Alternative to the" -- let's see what does it say? It was an alternative for standard analysis or something. I've forgotten exactly the title. I have it some place, but I guess I didn't actually put the specific footnote in here. I do have it, but it's not in this thing.

Q Any other publications except -- other than the AMA Guide that you are referring to but not citing?

A Well, as I said here, there are about 1,200 peer reviewed articles on Medline you can find if you look under biopsychosocial, that's going up fairly rapidly these days because there's actually a lot of articles now talking about it, so it's rising fairly rapidly. Of those 1,200, roughly 200 of them are relating to chronic pain syndromes. And there actually are now a lot of articles talking about this -- the last time I looked, for example, in spine, I think it was -- well, probably the year 2002, there were I think three major articles on the biopsychosocial model in relationship to spine disorders, if I recall correctly. And so I have some of them. I don't have all of these articles, but I have some of them in my files someplace. I have a whole box of files on pain articles and various kinds of things like that and some of those are in there.

Q Would the same discussion be true with your footnote B, that is, that it's a generic discussion?

A Yes.

Q That isn't necessarily geared toward Nick?

A Correct. In other words, it's -- well, it is only in the sense that I brought up in his context that the biopsychosocial model seems to be a useful model to invoke in analyzing his situation. And so in the broad sense that we often need to hypothesize in some of these -- because in some of these patients, and this is less true for Nick, but in some of these patients there's often not very much to work with that you can see on laboratory studies, so we end up, then, struggling under various kinds of hypothesized labels such as sprain or strain or that kind of thing.

Now, in Nick that's less true, although there is this whole discussion of the seizure issues in him. And depending upon how we end up finally concluding on that, we can invoke more or less of the -- of this discussion as it relates to him.

So this is not -- this is what you would call boilerplate, meaning it's a general piece that's relevant to things, but it is not specifically relevant to him. It's not written for him. It's more of a background of how do we think about these things.

It's -- and, again, the purpose of it is because some of this stuff is difficult and sometimes people benefit from getting a framework to understand how to think about these things.

Q Now, going back into your report marked as Exhibit 5 under the heading "Medical Records Review," I need to ask you -- let's see, if you have -- I guess you don't -- you can't verify whether you have all the medical records or not; is that a fair statement?

A Correct. That would require I knew all the records and then could correlate them with what I have.

Q But whatever's been given to you, you have reviewed?

A Yes.

Q For example, Dr. Russo, you have not see any records from her; is that true?

A I'm looking now to see if I've referenced her and I don't think that I have.

Q All right. Originally when you first started treating -- were you finished looking? Go ahead.

A Yes.

Q Originally when you first treated Nicholas, would it be a fair statement to state that you saw him as a referring physician from Dr. Vogeler?

A Yes.

Q And he presented to you having a traumatic brain injury, correct.

A Correct.

Q And it was an objectively diagnosed brain injury, correct?

A Correct.

Q Tell me what your understanding is of his current residual scans of the brain. What is visible, what is objective about his brain presently as you look at scans regarding any injury?

A Well, first of all, the word presently is a bit difficult there. If you mean presently meaning now, I don't know what might be his latest scan, so all I know is what we have in the records that I've looked at.

Q Let me back up and say to the last point in time that you have record of or that you know about.

A Let me, then, answer that this way. Let me go backwards through the records I have to see what is the last scan that I have referenced.

Q By the way, did you see the scans themselves or only the reports?

A I think I just saw the reports.

It looks like the last scan referenced is the one of Michael Goldstein from March 21st of 2001, and

at that time my note regarding what he said he saw was, quote, Findings are consistent with remote post traumatic changes. There are small hemorrhages and encephalomalacia at the frontal poles and left frontal convexity.

Q Convert that, please, into lay language.

A So the scan was abnormal and it was consistent with the conclusion that he had prior injury. The residuals included evidence of old frontal hemorrhage and structural abnormality of the frontal poles in the brain, which would be the area behind the forehead.

Q Meaning that what, they have atrophy, they are just distorted, what?

A The word atrophy was not used, but encephalomalacia means structural abnormalities which certainly can include that. So by using the word encephalomalacia, they mean that the brain is now abnormally configured, and under that could certainly be atrophy as one of the components.

Q What about generalized atrophy, are you aware of whether or not Nick's brain has suffered such from the accident?

A This report doesn't mention generalized atrophy. And as I said, that's the last report that I see in the records.

Q But what I'm asking you is do you know of any record that has indicated generalized atrophy of his brain?

A Let me look back to see what else we've got here.

Another scan that I see is from July of 1999. And, again, that reported small parenchymal hemorrhages primarily in the frontal lobes again.

Q So you have no opinion whether there was or was not; is that a fair statement?

A Correct on that one.

And then we had one from May of 1998, which was a CT brain scan and that was read as normal, that's a different technology, but that technology was read as normal. Now, it is noted, as well, that the CT brain scan of 1998 was negative and the CT brain scan of 1999 was positive; however, that may represent an evolution in the sophistication of the machinery, presumably it does not mean that he developed secondary hemorrhage, but -- I don't know a reason why he would do that, but I would note that those two reports say different things. So I know --

Q So it's consistent with the rather significant auto injury, isn't it?

A Right.

Q The hemorrhaging and the possible skull fracture and so forth?

A Correct. So I have nothing that I can see in my notes that said that anybody said he had general cerebral atrophy. Now, that doesn't mean he couldn't have had, I just don't have that in my notes and I don't see having referenced that in my notes.

Has somebody said that?

Q Well --

A I realize you're asking the questions, I'm just trying to understand the patient.

Q I understand that. We'll just have to deal with that another time I'm afraid.

A Okay.

Q I'm trying to understand, as you are assessing the paper review, what you're finding and what you think is significant.

A Okay.

Q Now, regarding your impressions and conclusions, since I've not had a chance to read them, with the exception of a few paragraphs, why don't you summarize what you believe to be, first of all, the areas that you have addressed and then we'll talk specifically about your impressions and conclusions.

A Okay. Well, as a neurologist, my main

interest is in his nervous system. I did reference other issues such as the lung contusion and abrasions, but my main interest, of course, would be in his nervous system and its function. And in the broad overview, the first perspective was clearly injury. There is no question he was injured and that he had highly objective evidence of quite significant injury.

That injury occurred not only in his brain, but also occurred as a lung contusion, multiple abrasions, and I also talk about low back problems and suggested his lumbar disc protrusion was probably related to this accident also.

Now -- so the first perspective is injury. The second perspective is the issue of the seizures and what are we doing with that. And as you know from our conversation the other day, when I first saw him and he began to mention these -- well, actually, when I first saw him, because he had a clearly objective brain injury and because some of these patients may develop seizures, I did an EEG, and his EEG showed some dysrhythmia, which was of fairly nonspecific type, not clearly seizures, but not, at the same time, excluding seizures. Given the fact that he had had this brain injury and had an EEG showing a dysrhythmia, then the question came up whether or not he could be having --

he could be at risk for seizures and, therefore, whether we should put him on medications, and I did put him on Depakote.

Now, what I don't recall off the top of my head, we would have to look back through the details to retrieve this, but I don't recall whether he mentioned he had spells at the time we first gave him the Depakote or whether it was the combination of just a clear head injury and an EEG showing a dysrhythmia that led to the Depakote. I don't remember which way that actually worked, so I would have to look back to see if there was any actual mention of any spells.

However, certainly, at around that time afterward or before, but around that time, he did develop, then, these reported spells and we put him on Depakote and his spells then improved. So putting together the issue of brain injury and the EEG and the report of spells and the report that the spells improved with the anticonvulsant, I then concluded he had seizures.

However, there also was in the background his prior history of depression and there was the additional observation that his EEG didn't show any definite seizure activity, so I put in the records, even in that early stage that I -- this was not a

confirmed diagnosis of seizures, but rather was a possible diagnosis and it was a strategic approach recognizing that seizures can get somebody into trouble and all of that.

Q You did reach a diagnosis, did you not, in your records that there was a seizure disorder?

A Right. And so -- yes, I did. And as I said, I also included in the records the recognition that that was not completely confirmed, but it was my working diagnosis. So we treated him for these spells and he did well and that supported the idea that he had seizures and then we went on with that.

Now, as you know, as this problem evolved, it eventually came that Nick stopped seeing me, and so then later when I got involved in this again when I was asked to review his record, then looking through the records what I found was that his spells, which were being labelled as seizures, were apparently being repeated and were apparently not so responsive to medications. In addition, subsequent EEGs had not confirmed seizures and, in fact, there was even the report that his ambulatory monitoring showed a lack of correlation between his spells and his EEG. So then all of that raised the question whether he really did have seizures, and that raises the question whether the

failure of the treatment as time went on was related to insufficient treatment of seizures or whether it was due to the fact that these weren't seizures.

So based on my review and in the August document that I generated, my position was that I had started him on these medications on the hypothesis of seizures based on early data, subsequent data did not apparently demonstrate EEGs confirming seizures, and his course apparently did not show good response to treatment, so then I brought up the possibility that I actually generated a mythology, the mythology that he seizures. Now, obviously, I don't intend to generate mythologies in patients, but it can be done accidentally and, you know, inadvertently.

So then when looking back, given, again, the perspective that subsequent EEGs did not confirm seizures, what I recognized was that it was possible, his spells were actually not seizures, that his response to the Depakote was either incidental or was treating his underlying depressive disorder and that the whole label of seizures was not really a confirmed pathophysiologic mechanism.

Now, as I told you the other day when we talked, I would consider this issue still currently unresolved based on the data that I have, okay, which

is I don't actually know if he had seizures or has seizures. Had meaning he could have had some at the beginning and perhaps his subsequent spells are now of other mechanism. Or it could be that he has seizures at this time and they are inadequately controlled, based on what I have read in the records at least.

But which is the correct answer? Well, as I told you the other day, that depends upon biologically whether we can confirm that there actually is a seizure pathophysiology going on. And as you recall, I suggested that it might be worth while for you to send him to the university to have them look at the issue to see if they can confirm whether his spells are actually seizures or not.

You also brought up the issue that apparently his family has offered the possibility that maybe he had seizures at the beginning, and you mentioned maybe that you thought only one of them was actually a seizure, and that maybe his other spells were not seizures, that they were some other mechanism. So I don't know that we know entirely, but it's very important to this patient, it's also important to you guys as you do your job, but it's important to this patient because ultimately we have to decide what we're treating, and in order for him to do well, we have to

try to treat the correct pathophysiology.

So at this time, my summary on the seizure issue is that I was the one that originally started it and based on early data, I did accept the diagnosis of seizures but subsequent information has apparently not clearly confirmed that process and my question now -- and I will leave it as a question -- is does he really have seizures or is that a mythology that I started and it is really not seizures, but some other kind of problem.

As I've already referenced, he had an underlying psychiatric disorder with depression and that's important because it can generate symptoms itself and then you get into the issue of trying to determine which mechanism generates symptoms that he may be claiming at this time. So, for example, if he's claiming cognitive dysfunction at this time or fatigue at this time or spells of altered consciousness at this time, which mechanism generates those? Is it brain disorder of structural type related to trauma or is it his depressive disorder and perhaps psychophysiologic mechanisms.

So that is something we have to try to analyze in the accurate care of the patient, but also in regard to what you all do, okay. And as I've said, and I told

you the other day, data can shift this thing one way or the other. In other words, if we have solid evidence that he's having seizures, then, great, that resolves the issue. If we don't have solid evidence that he's having seizures, then we would have to try to determine what is the nature and cause of the spells he may be having, and I say having recognizing that I've only looked at his records, I don't know what this man looks like clinically at this time, so I don't know what his current behavioral state is or what he claim at this moment.

So whatever information we have, whatever solid information we have would be very important in trying to determine what we currently view as the problem, and then when you have that perspective, you can then look backward to try to decide what do we think that meant in the early stage. So, for example, if it was true that he had studies at the university now, let's say, and they confirmed that he had an active seizure disorder, active seizure focus, then several things become important for him. One is that we've confirmed that that's the mechanism of his spells. Number two, you then have to determine what's the optimal treatment for the spells, medical or surgical or whatever. And number three, in regard to

prognosis, adjudication, that sort of thing, then you guys would have that information to decide your parts of it, whatever's going to happen there.

Q Let me interrupt you for a second. Tell me what tests you're specifically referring to or believe would be helpful in determining this?

A Well, he's had one ambulatory EEG, but I think having another ambulatory EEG or even inpatient monitoring at the university would be very helpful. Inpatient monitoring would be ideal. And before I finish that, let me just raise a point here. We're treating the patient. If he has no symptoms, then going -- putting him through inpatient monitoring would be a waste of everybody's effort.

So presuming he has symptoms now, presuming this is a struggle we need to struggle with, okay. So if we need to struggle with this, the patient is on medicines and we're not sure whether he needs to be on them or the patient is having spells that are not adequately controlled, if those are true, then I would suggest you consider inpatient monitoring at the university where they can look in detail at evidence for seizures, and they can also see what his spells look like to determine what is the relationship between those spells and any EEG findings that he may have.

If that did not answer the question, there are other tests that conceivably you could do. Over in Research Park they have MEG studies, magnetoencephalography, it's a research test and I don't know that you guys would want to get into it because it's not something that your venue may want to go into. In other words, it's research level stuff, but if you're trying to struggle, as I do, with how do you take care of the patient, you use whatever tools you can.

So over there they have a test and it is apparently quite sensitive for looking for evidence of active seizure foci. They have a thing called magnetic source imaging at Research Park which did not get out of the lab, at least at this moment. I think for technical reasons, it's very expensive and time consuming. But that technique apparently is highly sensitive, so conceivably if we really had to struggle, those would be something else that could be done in the struggle to try to analyze the problem. Certainly the most practical clinical approaches would simply be inpatient monitoring at the university.

If you can then use a test of that type and confirm the mechanism of his spells, you could then delineate not only the optimal treatment approaches,

but also you could delineate the whole adjudication discussion of that -- for that piece of it at least.

In regard to treatment for him if he's having seizures, there are various kinds of approaches. There are not only medications, but there's also such treatments as vagal nerve stimulators and even seizure surgery. If a patient has a focused seizure disorder due to a focal structural abnormality and if medications are not working well, there is an increasing interest in seizure surgery because you may be able to remove the seizure focus.

The enthusiasm for that type of technique varies depending upon different research centers and things and it's not something that everybody has agreement on, but certainly in the literature there is some increasing enthusiasm for that perspective.

Q Is that a fairly expensive surgery?

A It is.

Q And any idea what that kind of expense would be?

A I don't. I have no idea.

Q But it is relatively new, therefore, it will be fairly costly, I assume?

A It's not new, but I think there's changing views of its use. When I was going through training

and even up to very recent years, seizure surgery was relegated to people who had failed numerous medications and really were having refractory state. In the literature in recent years there has been the argument that if people have failed a couple of medications -- and couple may be too minimal, but there are some articles advocating that -- that if they have failed a couple of medications and they have a very clear seizure focus that we should consider the possibility of removing the seizure focus. And the reason for that argument is the observation of the costs to the patient of lifetime treatment, as well as side effects of medications and so forth. So the balances are shifting and there is more interest than there has been in the past.

Now, you can certainly talk to Fred Matsuo or Tawnya Constantino -- Matsuo is, M-A-T-S-U-O, and Constantino is C-O-N-S-T-A-N-I-N-O -- who are in the Department of Neurology at the university and are their epileptologists, E-P-I-L-E-P-T-O-L-O-G-I-S-T-S, and they can TELL you what they believe IS the role of seizure surgery at this time, so that would be a place for you guys to gather some more information about that topic.

Certainly it -- to consider it, you have to

have a very focussed lesion, you have to have something where we know that we have confirmed the patient's clinical spells are due to discharge -- you know, the seizure discharge in a particular area and we've seen that that area is recurrently involved so that we believe removing that area or fixing it would be useful.

Q How do you find that focused area? EEGs are more generalized, aren't they?

A Well, to an extent, yes. There are various EEGs and they have multielectrode EEGs and they have other kinds of techniques. You can use *SPEC scans and other kinds of things.

Q Would the MEGs be specific enough to locate a --

A Well, if they're out of the lab, yes. The MEG is apparently a good test from what I've heard, although as I said, it did not make it out of the lab to clinical practice in this valley at least, so we cannot order them as a routine clinical study, and even the word routine may have to be taken with caution here. It's not something you would use on every patient because it's very expensive and difficult to obtain, but we cannot order them as a way of analyzing patients on a routine basis.

So you would have to talk with the guys at the Department of Neurology at the university, the epileptologists to see what they say and what they say is the role of that test and whether or not they send patients over there and how they choose who they send over there to see what they have to say. And I don't know what they would say at this point. I also know you may even get difference of opinions between the two of them. These are not easy issues and there are patients who, you know, can get differing opinion even from very good sources. So I don't know what they would say in regard to Nicholas, but you can certainly check to see what they would say.

The other way of looking at it is --

Q Before you move into the other etiology -- I assume that's where you were headed?

A Actually, I was going to go the other way, so looking -- for seizures, you can actually do cortical recordings. If they think they are down to the problem well enough, they can actually record off the cortex of the brain. That's rarely done because that means you have to open a person's head, but -- and so they would not go there with Nicholas, I don't think. But the point is, there are other techniques that can be used and certainly the guys at the university are going to

be the ones who are best qualified to tell you what the current state of the art on all of that.

Q Out of all of those procedures, you would recommend, as you presently understand the situation, the U of U studies as you have described, and if not consider and explore the EMGs?

A The MEGs.

Q Sorry MEGs, I misstated.

A Yes, yes.

Q Now, on the vagus nerve stimulator, tell me what that is -- what that involves and the nature of that treatment.

A In interesting curiosity, it has been found that stimulating the vagus nerve may abort some kinds of seizures. That has been pursued and there now is an implantable stimulator which is -- the stimulator itself is put in the upper chest and wires are run to the neck where the electrodes are placed around the vagus nerve in the neck and the patient then receives intermittent stimulation of the vagus nerve over the course of the day.

With that stimulation, you may produce control of some kinds of seizure disorders. Vagal nerve stimulation should be reserved for only a very selected subpopulation because it's got risks and it's very

expensive and you can have infection problems and other kinds of things. But, again, if you have confirmed that a patient has a definite seizure disorder which is refractory to medical management of the usual medicine, then it is something to consider.

I would only consider that from the university, and the reason is that there are some places in this state where I think their criteria for inserting the stimulator is perhaps much lesser than the university would use and I think there's sometimes a question of whether there are economic issues playing. So I would personally suggest that if you look at that, you take the university's opinion on that subject.

Q Now, since I understand you to say that the jury's still out in your mind as to the source of these seizures --

A Or spells.

Q Spells or seizures, whichever they may be -- I guess let me back up and say, regarding the nature of this particular kind of brain injury and its residuary effect on the frontal lobes, this kind of seizure activity is certainly consistent with such injury, is it not?

A Oh, yes.

Q And it isn't a remote stretch to reach the conclusion, as you did, that they are related to the brain injury?

A Not at all.

Q All right. Now, what other opinion do you have?

A I also --

Q Let me back up. Assuming that this is an organically caused seizure, what has been your experience in terms of this type of history, that is that there were some perhaps more significant seizures and now these spells that continue to occur, what type of prognosis or future is someone with this kind of condition looking at?

A Well, that's a very good question and it gets down to the point of which specific pathophysiology accounts for the continuing spells. Even as you referenced the other day when we talked, it's possible that he has more than one pathophysiology. So, for example, it's possible that he has seizures and he also has psychiatric induced spells. We know, for example, that pseudo seizures, which are psychiatrically induced seeming seizure events, are most common in patients who actually have seizures. That's a very complicated subject, but the importance of it in this patient who

has an underlying depressive disorder is that for him to do well with treatment, we have to try to be accurate about the actual mechanism.

So he could have more than one mechanism, he could have some seizures and some pseudo seizures, or he could have some seizures and some other kind of spell, but if that is true, then the prognosis for the different spells depends upon what each of the spells is due to and depends upon how each of the spells is behaving.

Q Well, that's why I was asking to assume that these are physical in origin as opposed to pseudo. And by the way, why don't you just quickly define what pseudo means to you as you're using it?

A Well, pseudo seizures as people use it in the literature means that it's something that may casually or even to an expert appear to be a seizure, but is, in fact, not a formal seizure process, and the seizure process is that group of physical or behavioral symptoms which may derive from brief bursts of abnormal electrical brain activity.

Q All right. Still appearing to be a seizure because of an abnormal electrical brain abnormality, but its cause is not physical in origin, or am I understanding you right?

A Not quite. In other words, the word seizure encompasses all those manifestations which derive from a singular type of process. The process is abnormal brain electrical activity. Now, if you change the focus out to the symptoms, then there are patients who have symptoms that may look like seizures, but they don't have that abnormal brain electrical activity, they are not -- the symptoms don't stem from that process.

So the simplistic example there is what is hysterical seizures or what are routinely in neurological parlance called pseudo seizures, which means they look like seizures, but they aren't and they're usually psychiatrically generated events. It's not -- even that differential diagnosis is not entirely complete. In other words, a person could have -- technically could have a pseudo seizure due to a cardiac arrhythmia, that would be technically a pseudo seizure, meaning it looks like a seizure, but it isn't; however, people don't generally use the term in that way, they generally use the term pseudo seizure to imply a psychiatric mechanism.

Q All right. Now, going back to my original question. I was having you assume that these spells are physical in origin, you've seen how they've been

described in the records. Assuming they are physical origin, that is, originating from the brain injury, what prognosis does someone like that have?

A It depends upon how well we can control them, so...

Q So the medications thus far don't appear to have affected them significantly, they would at least at times -- well, you know the record, go ahead and explain.

A So from what I can tell in the records, it sounds like the medicines have not been effective in controlling the spells. That means one of two things, the medicines are not -- well, actually, one of three things. First, it could mean the medicines are not effective because we have not found the right medication or medications. Secondly, it could mean that the medication was not effective because medications as a strategy are not sufficient for the problem. Thirdly, and you're excluding this one in your current hypothesis, is that the medication is not effective because it's not really a seizure disorder.

But now if we consider that there are patients who have seizures who will fail medications because medications are not able to control the underlying process, then we look at the other alternative

treatments, such as the vagal nerve stimulator or epilepsy surgery as I mentioned.

Q Otherwise these spells or seizures continue on indefinitely, is that the bottom line?

A The usual prognosis for an established post traumatic seizure disorder is that it's permanent, the usual prognosis. That's not always true, but that's usually true.

Q With age do they progressively worsen?

A Usually not. They can, but usually not.

Q Now, go ahead with the rest of your opinions.

A So one issue, then, is the seizure. Second issue is behavioral consequences of brain injury. So then you get into this very elaborate area of what kind of behavioral changes may you reasonably expect as a biological derivative of brain injury, and that's a complicated area to talk about. One of the most interesting and often referenced examples of that discussion is the *Fenius Gage argument. Are you familiar with that?

Q I am.

A So that whole one is very interesting because it represents the observation of marked behavioral changes due to frontal lobe dysfunction due to anatomical severing of some of the frontal lobe

pathways.

So we know without question that if you injure somebody badly enough you can produce behavior changes. Now, in this man, then, who has had underlying behavior disorders, what do you then do if he has continued behavior disorders, to which element do you attribute that? Do you attribute it to his underlying problem or do you attribute it to his injury problem?

Q Or a combination?

A Or a combination, exactly. And that's going to be difficult, but it is a reasonable place for us all to struggle because it is reasonable to wonder what his behaviors may have done or what may have been done to his behaviors by his injury.

Q Certainly the literature is replete with examples and research of how if someone had some depressive disorder, a brain injury to the frontal lobe often aggravates that. You're familiar with that, are you not?

A Well, that's an interesting question. First of all, can it aggravate it, yes. Does it often aggravate it and how does it aggravate it, that becomes much more difficult. Let me tell you what I mean by that. First of all, when we're discussing these things, you have to recognize that very commonly we are

talking in terms of reported symptoms rather than path -- than observable quantifiable pathophysiologic mechanisms.

So if you were to go to Africa where people do not have all of these kind of social context such as we're currently involved in and somebody had a head injury and previously had a head -- had a depressive disorder and their behaviors changed afterward, you could reasonably assume this is probably going to be somehow biologically interlinked and the Fenius Gage discussion is a very great example of that.

However, when you get into societies where there are these other social issues, then the problem you struggle with is how do you know that the patient was biologically changed versus the patient was sociologically changed, that is to say their underlying disorder, which was *self-quailing because it was their own responsibility now suddenly becomes self-reinforcing because it becomes somebody else's responsibility. So then if the patient changes, are they changing because of the change in sociologically *milieu or are they changing because they actually had a biological change in their brain structure. So it's a tough area.

Q I understand that the etiology or the actual

cause of change can be difficult to determine, that's not my point. That was not my question. My question is the literature recognizes, does it not, that there's a correlation between frontal lobe injuries and aggravation of any preexisting mental disorders?

A Yes, there is some correlation. Does that mean it's true in every patient, no, but there is correlation.

Q In the high percentage, correct?

A Well, show me the articles you're referencing, let's look at the population base that they drew from.

Q I'm just asking you based on your knowledge of the literature. If you don't know, that's fine?

A Well, it's not that I don't know. It's rather that when you say high percentage, which specific references are you talking about and what do you mean by high percentage. So let's back it up and look at it this way. If you look at people who are involved in brain injury where there is no secondary gain involvement, that group of people infrequently argues that their underlying state was changed permanently. Now, not zero --

Q What's the foundation for that opinion?

A My foundation for that opinion is my experience over the years of seeing patients with those

kinds of situations, that's where I get that perspective.

If -- so, now, does that mean that no one ever claims -- ever -- let me rephrase this.

Does that mean that there are no patients who assert there is a worsening? No, that does not mean that there are no patients who assert a worsening -- there's a bunch of negatives in there, but what it means is that when there's no ax to grind, usually from a standard brain injury, people do not assert their behaviors change.

When there's secondary gain issues, they may and much more often do. In fact, when there's secondary gain perspective, then there's a very high percentage who report that they're worse. But that's in that secondary gain population, it is not what we see in the nonsecondary gain population.

Also -- and Nicholas, for example, he went on to become suicidal. Suicidal behavior is a very interesting discussion, but it is not what derives from normal brain injury. And the reason for that is suicidal behavior is a derivative of people who are emotionally isolated, they are not well connected, they are not well interrelated to other people so that the idea of escaping the world on that basis is more

acceptable to them. That's a very broad statement and it's not going to apply to everybody, but it's a generalization. It works fairly well.

There are certainly people who enter situations which are so abhorrent to them that they may become suicidal, such as a person who loses their entire, you know, personal fortune or something. But suicidal behavior occurs in certain types of individuals and there are certainly people who -- lots of people who have terrible injuries and terrible problems who don't become suicidal, they may become depressed, but they don't become suicidal.

So this is a difficult area, and I don't want to paint it as if we can polarize it to all or nothing discussions. We're talking about shifting potentials and possibilities, therefore, if you looked at Mr. Sorensen's later suicidal behavior and said statistically what's most likely, is this most likely to derive from his underlying depression or is it most likely to derive from his brain injury? I would argue it's most likely to derive from his underlying depression. That's my opinion.

Q Have you reached an opinion whether or not his underlying depression presently has been aggravated or enhanced by his brain injury?

A Well, again, I have not seen him in a long time, so I don't know what he looks like or what he says. All I can tell you is in the records it does -- the records seem to shift over time to quite a focus on his psychiatric state and seem to focus to, for example, his suicidal levels of depression. And the question then comes up where does that come from, is that a derivative of injury or is it a derivative of, you know, psychology and sociology. And in treating this man, that has a big and huge impact because if you're going to try to treat him, you have to understand which mechanism is promoting the current state.

So my view at this time is that while there's no question Nick had very significant injury, no question about that, I think most of his depressive behavior is probably derived from his underlying illness rather than from the consequences of injury.

Q Maybe this would be a good time to start. You've mentioned a number of times that he's had a depressive disorder. Can you tell me specifically what you're referring to as a historical depressive disorder?

A Let's see where that came from. It was way back at the beginning when that all came out, and I

believe he told me about it, but let me look back and see.

Yes, he told me about it. When I first saw him in August of 1999, he reported that he had been depressed and that he had been on Effexor, and he also made reference to having been jumped a year prior by some gang members or somebody or other and that the problem had gotten worse at that time.

Q Let me see what you're referring to. Is that your history questionnaire?

A Yes. And that's -- this is my writing here. This is whoever filled in the form, him or whoever, that's their writing. This is my writing of what he told me at that time.

Also --

Q Now, let me -- go ahead. Anything else you recall about -- other than being jumped?

A Well, here's what he had told me and what I wrote in my August 4th letter. "He apparently had depression in the years past which became worse a year ago when he was jumped by some gang members. Quite recently, he has been tried on Effexor, and we do not know exactly how this is going to work as he has just recently started it."

Q That is your understanding of what was

reported to you, that he was on Effexor at the time of the accident or at the time you saw him?

A At the time I saw him, yes.

Q And that this -- that for what period of time had he had any depressive episode prior to being jumped by this gang?

A Well, he told me years.

Q Where is that said?

A On the bottom of the first page from the August 4th, 1999 letter.

Q But I'm saying, is there any reference in your notes that he either wrote or that you wrote down while interviewing him where he said he had been depressed for years?

A Well, let's see.

Q There's a difference between being depressed for years and then what you put he apparently had depression in the years past. That seems to mean something very different.

A Well, now we're into semantics, and at the time that I'm seeing him I'm just taking care of him, so I'm not writing a letter that's going to stand up to legal scrutiny of every word.

Q But I'm trying to understand what you know regarding any depressive history, because there is not

a record of such history.

A Okay. All right. So if there is no record of such history, then I would simply go -- and by the way, you have to go back to whoever gave him the Effexor probably, but that's all that I know and that's what he told me. I'm just simply writing down what I understood him to tell me.

Q That's what I'm trying to understand. Where is it that you wrote down that he had had depression for years?

A Again, I made the note that -- of what he told me there and what -- the way I wrote it, the way I wrote my note -- I mean -- let me back up.

When I'm seeing a patient, we are -- I'm writing down handwritten notes of things that people are saying to jog my memory for the dictation. I do not write down every word they say, nor do I write it down in such a way as to try to answer every possible question about it. So I'm trying to make some notes that I can then refer to.

Q But do you have notes that talk about any years of depression, that's what I'm asking? Or is this something you remembered and then put it in your letter of August 4th?

A It's what I wrote down in my letter to

Dr. Vogeler from what he told me, and exactly what words he used, I cannot tell you.

Q Is there anything in the history questionnaire that refers to being depressed for years?

A No.

Q I can't read your writing, I'm just asking you if there is anything in there?

A No. Do you know him gave him the Effexor?

Q Are you asking me to answer the question?

A Yes.

Q I think I do, but go ahead.

A What I would suggest is that you look at the records of whoever gave him the Effexor --

Q We have.

A -- and see what they say.

Q That's why I say there's not a history of what you're describing.

A Then the other possibility is that I misunderstood him.

Q All right. But, anyway, you have reached your conclusion that most of his behavioral problems are a result of a history of depressive disorders; is that right?

A Well, again, I'm going on the fact that he had the underlying problems and then I'm going on the way

the problem played out over time and observations regarding this issue of depression in the setting of head injury.

Now, having said all of that, a few things. First, I would not advocate that everyone who has head injury is free of depression. I would not say that. Certainly people may get depression after a head injury. I would not advocate any hypothesis that said that head injury could not produce mechanisms which set in motion a depression, they can.

In this man, my understanding of the problem at the time was that he had background depression, if that understanding is incorrect, then I'm sorry, that was my understanding, okay.

Q I'm not saying he didn't have a situational depression. I'm asking you what you know about it if anything?

A No, that's all I know is what I have in those records.

So if he had -- if he had a brief or situational depression and if that was not, then, an underlying tendency, then you would make a stronger argument for this problem being related to head injury; however, as I've said, if you look at the behavior of suicidal depression, it is not a common result of

natural head injury syndrome, and there's lots of places to look for that kind of perspective, but it is not a common thing. It's not impossible, it's just not common.

Q Now, have we covered all of the information which you know about --

A No.

Q -- from which you have drawn a conclusion that there is a history of depression?

A Oh, yes, I believe we have.

Q And you're conceding that without additional information the more situational the depressive episode may have been, the more that that would indicate that the component causation of the seizures may be -- pardon me, of the depression may be head injury of origin?

A Correct.

Q Go ahead with the rest.

A Just to set a couple of issues aside because you asked me a long time ago what other issues were in my report --

Q Have we covered all the seizure disorder issues?

A I think we have. I think we've talked about that topic as far as we can really go with it.

We -- and then so now we've talked about cognitive issues.

Q Behavioral issue?

A We haven't talked about dementia. In other words, is there evidence that he is demented? And what I can tell you about that is simply that apparently Dr. Bigler and Weight thought his intellect was basically normal, so they did not find evidence of dementia as I understand it.

Q What is the perspective risk of developing dementia or onset of dementia earlier because of a head injury of this kind?

A Well, that's a very good question. And, again, I think it depends upon where you look. Again, if you look at injury clinics, you've got -- American injury clinics you have to be a little careful because they have a selective subpopulation and some other kinds of issues. But if you look sort of broadly, I think there is some literature supporting the idea that with enough injury you certainly can develop a dementing process. The place where that was originally discussed was in the punch drunk syndrome or the boxer syndrome or the pugilist syndrome which basically was the context of multiple small head injuries resulting in multiple disconnections and eventually in some

people a dementing process.

Interestingly, that's certainly not everybody, it is only some. But it is in the literature, there's no question that that can occur. So it is possible for head injury to predispose to dementia, but how much a single head injury, even a single sizeable head injury predisposes to dementia is a much more complicated discussion and has much more tenuous footing.

One of the places you can look at that question is the issue of stroke. In stroke we have very clear head injury. Now, it's a different type, and that's important, so we're not talking about the mechanical force type, we're talking about vascular type, so it's a different type, but there's no question there's a big injury in stroke, and so then the question comes up how many patients with stroke end up with dementia? And they can from multiple strokes, but they don't generally from a single stroke.

Dementia is a term which may be used in various ways. If you use the term very broadly and you have a person who has stroke who has a speech problem, you could call that dementia, because you could call that a decrease in function that relates to intellectual function, but generally the term dementia is a more broader view of the ability to integrate and

process information, and that concept, that broader functionality concept, we don't see a lot of dementia following single strokes. We could, but we don't generally. We may after multiple strokes, such as occur in somebody who has cardiac emboli and that sort of thing. So the multiple stroke thing begins to look much more like a punch drunk syndrome, which interestingly is another example of multiple smaller injuries.

So, is it possible for Nicholas to get dementia from his event? I think that's a discussion. I think my own opinion is that dementia from this event would not be highly probable. I don't think it's impossible, but it's not highly probable, and I think when we look at patients who had head injury and there is no secondary gain setting, late development of dementia doesn't seem to come out of that discussion. So I'm not excluding it, I'm simply saying it would be my opinion that this is probably not a likely outcome.

Now, you mentioned earlier cerebral atrophy. I don't know what scans you may be referencing in bringing out that concept. If we actually have data demonstrating that he has cerebral atrophy, given his youth and given the fact that he had objective injury, I would then need to give more credence to the

possibility of him developing dementia from that event.

So I've told you statistically a perspective, but if you actually could show me scans that have argued he has diffuse cerebral atrophy, I would certainly be willing to reconsider that point in his particular case.

Q Fair enough.

MR. ALDERMAN: Rich, can I interject here? Should we give a court a call?

MR. HUMPHERYS: Do you mind if we take a break?

THE WITNESS: Sure.

(Break taken.)

Q As I remember, we were talking about dementia and concluding our discussions about dementia. Do you have opinions as to other parts of what Nicholas is complaining of, either behaviorally or cognitively or whatever?

A I think the disc problem that he had is related to the accident.

Q You mentioned that.

A Right, and do you want to talk about that any more or not?

Q Well, let me just focus on the brain injury, if I could. Is there anything else about his

behavioral problems. You may have seen in the records he has a flat affect, that's consistent with a frontal lobe injury, isn't it?

A That can be a frontal lobe injury, right. It can also be depression. As all of these things are, you have to try to see if you can determine what's the mechanism that generates the response. So if you think the mechanism that generates the flat affect is frontal lobe and the Fenius Gage discussion, okay, then there's that. And if you think the flat affect is due to depression, then there's a different set of mechanisms and a different set of treatment options.

Q If the mechanism of the depression is -- has its origin in the brain injury, is the treatment any different than if the flat affect were simply a direct result of the injury to the frontal lobes?

A Yes.

Q In what way?

A Several. First, if the mechanism of depression is due to brain injury, then counselling is worthless because you're not talking about this being based in belief systems or value systems or experience. It's not going to get you anywhere. That's not the foundation of the problem. It's basically something you just approach pharmacologically.

You know, some degree of minor counselling could be useful simply at an adaptive level. In other words, how does a person get along in their life given that they've got a brain injury, but any kind of Freudian or behaviorist approach to going back to, you know, what you think might generate the depression is going to be a waste of time. This would be a biochemistry, it's not an experientially based phenomenon.

On the other hand, if you think the depression is based on the anguish discussion and has an experiential foundation, then, as we know, we can help people by trying to re-orient the way they approach the world and the way they may be processing old information, and so the treatments are quit different at that level.

Also, medication wise, if we think that the disorder is purely structural and frontal lobe generated, then medications that activate frontal lobe functions may be more beneficial, Effexor, for example, being one example or possibly Wellbutrin might be more useful whereas *serotonergic drugs that have more to do with downward descending pathways and limbic system may be less useful, so the pharmacology changes some.

Also, in regard to prognosis, if you believe

that the mechanism of the depression is a residual of old brain injury, then the prognosis is the patient will have a permanent disorder to whatever extent that nature does not fix the injury, and by this time nature will have done what it can with regard to his injury.

Q As good as it's going to get.

A As good as it's going to get, yes. So if you believe that the mechanism of the depression is structural from his injury, then you're talking about a permanent problem and the whole treatment strategy becomes living with permanent residuals. If you believe that the mechanism of his depression has a lot to do with experience and behaviorally based depression, then he may be much more curable because it may be that he could get, you know, change in view of early experiences or prior experiences or value systems or belief systems and those could lead to, then, much better outcome in his overall function and capacities.

Q If it is a combination of the two, which it very well may likely be, then I guess you have that problem of the structural part never resolving, but the behavioral or experiential part improving or not improving depending upon how the structural part effects them?

A Or depending upon how a person can modify

their --

Q Adapt?

A Adapt in their foundations for behavior. You know, this is difficult stuff and we don't have crystal balls so we can't delineate entirely how it's segregated, but the importance for this young man is here he is in the early part of his life and you want to give him his life back as much as you can. So as best we can, we want to try and figure this out because then we can determine what we possibly are able to do.

Q And therapy, at least to the extent that it's behavioral or experiential, as well as adaptive in nature, can help him give back as much life as possible, if I understand what you're saying?

A Well, no. I think cognitive therapy is going to be fairly useless if you believe it to be a structurally based disorder. You can do some simple things. You can do some things like saying, Well, okay, here you are, you have this permanent problem, how are you going to manage your life with it? But you can do some fairly simple things only. Let me jump outside the brain for a second. If a person had a leg dysfunction, a leg paralysis and it was due to a stroke, you might give that person some brief counselling to say, Well, your leg is permanently

paralyzed, but here's -- let me help you a little bit with the emotions, but mostly you are not going to spend a lot of time on counselling for that sort of thing, that's simply adapt and move on.

On the other hand, if the person's paralysis was hysterical, then counselling may do a lot for the underlying mechanism of the problem, possibly even to the point of returning the person to function.

So I think if you believe that his disorder is mostly structural injury, then counselling is going to be more or less a waste of money, more or less. Brief counselling, to the extent of simply giving him some adaptive skills, here's how you move on with your life given these residuals could be useful, but it's going to be fairly brief. And long-term counselling is probably not only going to be not helpful, but may actually entrench him in endless behavior and may encourage propagation of the problem. So if you really believe that most of this is due to structural injury, I would not suggest a long-term counselling session. I think most of it you're going to do is going to be pharmacological.

Q Now, before we leave the head injury side, I would like to ask you, you've raised a lot of issues which are certainly appropriate issues to query, but

what I want to know is, have you reached any opinions about Nicholas Sorensen, in your judgment, has the traumatic brain injury resulted in an aggravation of or cause of any of these behavioral or emotional problems you've referred to?

A My opinion at this time based on the data that I have is that his behavioral state is probably more to do with underlying, you know, depression and issues than it is with injury, that's my opinion at this time. And we've talked about the various ways that opinion could shift based on data, and we've talked about variations, but that's my bottom line.

My opinion is that I'm not sure whether he has a seizure disorder or not because subsequent EEGs have failed to reveal it and his response to therapy apparently has been poor.

My opinion is that he clearly did have an injury and that there probably are some residuals, but I think other issues are compounding those residuals as I just mentioned.

And then we have not spent time on the disc problem, I'll just leave those, but that's also in there.

Q Now, you mentioned it two or three times about the disc being related to the accident. Is there

anything more that we need to talk about?

A No. I mean --

Q You're report's fairly clear on that.

A I think it is. I think we don't know of any underlying problem where he had that. We know that this injury was big enough that certainly we could expect he could have had a disc injury and, you know, he was young enough that you would not expect this to be incidental, so I think it's related.

Q Any other opinions you have relating to Nicholas Sorensen?

A Yes, I have the opinion that we should struggle hard to try to determine some of these areas that are vague to us for him because it's his life and, you know, we've got to try to figure this out as best we can. So if you can get the stuff at the university and if they can give us further information, that may be very helpful.

Q Okay. Anything else?

A No.

Q All right. I would like to ask you about some additional questions now that we have your opinions, hopefully, described in great detail. Let me make sure I reassemble these exhibits properly.

On Exhibit 2 -- do you have that in front of

you?

MR. ALDERMAN: Right here.

Q There are two Post-its that appear on this, and for whatever reason, I don't know, we didn't get those Post-its at the beginning when we had requested the records. This -- or do you know where this came from, these Post-its, whose they were?

A Yes. Those were, I think, his. I mean I don't know who came to the window, but what I think happened with this is that I sent the letter of 9/15 to him, I think, I think that's where he got it. And then I think what happened is he or somebody came to the window and said he wanted one of the sentences removed, which was the sentence about the depression and that being present prior to the accident and the -- this was written by the secretary, these two little Post-it notes. The -- there's a phone number there that says Nick and then it gives a phone number, which I'm gathering is his phone number.

So I would presume he came to the window and said I would like that sentence removed. I don't know if he came to the window, but that's what I'm presuming.

Q And help me find that sentence. I'm not --

A It's in the copy that you have -- well, you

may have two copies. But in the copy that shows the Post-it notes, it's underneath the Post-it notes, so it's --

Q There it is, "Nick has done generally well although he has had continuing depression, which is a problem present prior to the accident." And he's saying that he had depression in 10th grade. Do you know what that surrounded, what situation that was relating to?

A No, and I don't know if that was the gang thing or not.

Q But in any event, we have his note to you that he had a depressive episode in 10th grade or sometime prior --

A Right.

Q -- a year or more, a year or two prior, and you recall the issue regarding the gang jumping him?

A That's in the -- my original report. Again, it's something he told me.

Q Yes.

A But, again, now, was that gang jumping event the event that's referenced here in the 10th grade, I don't know.

Q Now, let me see if I can clarify a few things. In Exhibit 2, it appears that your first contact with

Dunn & Dunn was a letter in May -- I believe May 14 -- wherein a subpoena was enclosed ot appear at trial together with a check of $18.50 as an appearance fee. Do you see that in Exhibit 2?

A Yes, I think so. I've seen the letter of May 14th, and then I'm seeing that $18.50 check, yes.

Q And the subpoena just behind it?

A Yes.

Q Prior to this time, had you had any direct contact with Dunn & Dunn to your knowledge?

A If there's no other letters, then the answer would be no.

Q I don't know of any, but I don't know of any oral communication either, so I'm inquiring --

A I don't think there was any. I don't know if anybody called. I don't think anybody called. I think that's when it started.

Q Then we have a letter which is closer to the top of Exhibit 2 dated May 23, again from Dunn & Dunn, and it's in response to your letter of May 23rd where you indicate that you normally charge $315 an hour and that you didn't want to presume anything but assumed that they would pay and you wanted that confirmed. Is that kind of a fair synopsis?

A Yes.

Q The May 23rd response back, which is the same day, I assume these were faxed back and forth, it indicates -- Ms. Hanson indicates, "Of course we plan to pay you at your rate of $315 per hour for your appearance." And then it says, "In fact, we wonder if you would be willing to spend several hours, approximately five, and review all of Nicholas Sorensen records. We would like to know what you think, as his treating physician early on in his injury, about his current condition. Let us know and we will see if our client will authorize something like that."

Now, at this point in time you understood that Dunn & Dunn was representing Marcelises, correct?

A Yes, I don't know that -- yes, I presume that is the case. I'm not interested in that particularly, so with regard to somebody, if you would have asked or if they would have asked, I was more interested in somebody simply asking for my opinion. But I believe that that is correct, that that is who they represent, yes.

Q Then in the page immediately before on Exhibit 2 is another letter or a memo dated 5/23/03 where you are responding apparently and saying that you would be happy to review the rest of his records and include this in your overall assessment of his illness.

And then you indicated, "It's always a pleasure to see the rest of the story."

What was your understanding -- was there any information provided to you orally in conversations during this period of time?

A I don't know. I certainly have no recollection if there was some sort of discussion on the phone or not, I don't know. So all I know is that their office contacted my office with these things as you see here to basically ask me to evaluate this patient's records and then talk about my opinion regarding him. With regard to -- was there some phone conversation, I don't know if there was a phone conversation.

With regard to the rest of the story, that's probably a reference to the letter of May 23rd where it's asked if I would look through the rest of the records, and I put that in there because, you know, we get these snippets of people's lives when we get to see them, and part of the thing that's very revealing is what happens later, how does it play out. And so finding out what happens afterward is very interesting and useful, so I probably was going, yes, I would be happy to know what happened.

Q So the fact that that was said doesn't mean

that there was conversations between the two of you or someone else at Dunn & Dunn?

A No. That was probably a reference to them asking me to review the records.

Q Then next we have is Exhibit 3. That is a letter from Dunn & Dunn dated August 1st, 2003 addressed to you and it starts out by saying, "Enclosed please find copies of Nicholas Sorensen's medical records in the above referenced matter. You treated Mr. Sorensen following an automobile accident on July 24, 1999. We would like you to review his medical records and give us your opinions about a couple of things. The following is some information about what has been going on with Mr. Sorensen since you last saw him," and she then provides some additional information there.

On your copy it has highlighted the words "we would like you to review his medical records and give us your opinion." Tell me why that was highlighted, do you know?

A I don't know who did that. I don't know if the secretary did it or what. I don't really know where that came from, whether that was there when we got it or whether it was something that my secretary added, it could be either.

Q Was this the only communication you had had prior to those correspondences which we just reviewed in May up until this time?

A Well, again, I don't recall if there were any phone calls or discussions. I don't know. So what I know about is simply what it talks about in these letters. My understanding of it was -- and basic overview that I had seen this patient, he then had gone on to other people, you guys have this litigation, they had, then, looked at my opinions, they had, then, asked me to review the rest of his records and tell them what my opinion was based on the original stuff and also my subsequent review of the records. That's my basic understanding of the situation.

Q In the fourth full paragraph she asks you -- well, let's see. She's asking you I guess -- or she's presenting the issues she wants you to address; is that correct? "The question we have is to what degree his current issues are as a result of the injury and what those issues might be as a result of problems Mr. Sorensen had prior to the accident."

A Yes, I think that was the basic overview of the question they had.

Q Now, the last paragraph -- well, let me back up. This is fairly consistent with when you were

retained to do IMEs on a cold file review except you've had a little history in treatment years before.

Let me rephrase that. What she's asking you to do is fairly consistent with a cold file review, correct, that is, she's sending you records, look at this and --

A Tell us what you think.

Q -- tell us the issues?

A Yes.

Q Now, in the last -- on page 2 of Exhibit 3, the first paragraph says, "After you have a chance to review his records, give me a call so we can discuss your opinions about Mr. Sorensen's progress over the last several years. There are several issues we would like you to address but we can talk about those when you call."

Did you respond to that request?

A Probably did. Yes, I did call, and that's why I didn't send this report that I have here, is I did call and talk to them.

Q In your discussion with them -- do you know who it was you talked with when you made the call? Was it an attorney, was it Ms. Hanson, was it a group of people or do you remember?

THE WITNESS: I think we talked, didn't we

talk? Did we talk?

I don't know for sure whether I talked to Kay at that point or whether -- who I talked to at that time. I don't know for sure.

Q Anyway, it was someone from Dunn & Dunn?

A Yes.

Q And had you prepared your report at that time?

A Let's see, what's the date? No.

Q August 11?

A No, because this was -- well, actually, let's see, I probably did. Yes, I probably had done that because this, as I said, I did concurrently when going through the records. So what would happened is I would have gone through the records, made all of my notes, made my conclusions so I understood what I was thinking, and then I would have called up and said here's what I'm thinking.

Q All right. And then talking with someone at Dunn & Dunn's office you went through the various opinions in your report, correct?

A Correct.

Q And then were you going to send that to Dunn & Dunn?

A I think they asked me not to at the time.

Q Do you know why?

A No. Some sort of legal issue I guess.

Q Did they ever suggest that they did not want to refer to you as an expert or a defense expert?

A I don't know. They may have, I don't know.

Q And then after preparing that report, reviewing it with Dunn & Dunn, what was your next involvement in this case, if you remember?

A Well, look at that billing thing. Let's see what the billing thing says.

Q That's Exhibit 4.

A So let me see the date here -- so the next thing was, then, the meeting that Mr. Alderman and I had on the 16th.

Q Of?

A Of September, where he came to talk about my opinions.

Q Is this the first face-to-face meeting you had had with anyone from Dunn & Dunn?

A I believe it was.

Q And are we talking about a half an hour to an hour?

A That was two hours, it looks like. It would have been -- well, it's whatever $351 into $787 is, that's probably like two and a half hours or something like that, and it probably would have included the time

I prepared for the thing, which is probably, I don't know, an hour, 45 minutes, something or other and whatever time we met. So I don't know exactly what the time break down is, but it would have been something like that.

Q Any further communications until our office contacted you to meet last Thursday?

A No, I don't think so -- well, wait a minute. That's not true probably. I probably called him to tell him that you were coming because you guys have all of your legal stuff and I'm trying to be very delicate with that stuff, so...

Q So the record's clear, the pronouns you're using, when we contacted you to meet with you, you called Mr. Alderman to tell him that I was going to meet with you?

A That you were coming, yes.

Q I see. Was there any further discussion regarding that?

A No, I think I just told him that you were coming and that was it.

Q In your meeting of September 16, did you provide Mr. Alderman with a copy of the report or did you show it to him, allow him to read it?

A I don't know if I did that. I actually may

not have because I think I gave -- I know I didn't give him a copy of it because I think I gave him a copy today when I gave you a copy. So that's the first time I think he's seen a copy?

THE WITNESS: Is that correct? I think that's correct.

MR. ALDERMAN: Yes.

Q In any event, you discussed the substance of that?

A Yes.

Q Now, when I met with you last week, I believe that you indicated -- and when I asked if you had prepared anything, you said you had prepared a report, you referred to it, but when I asked to see it, I think you indicated you thought it would be attorney work product or something such as that.

A Well, it could be. I didn't know how you guys would handle that issue. In other words, you have your own sets of terminology and your own sets of rules and I'm not familiar with all of those rules, and I have had one very unfortunate experience, which you probably know about, that has to do with one of these things where there was some nuance I did not understand and that created problems. So I try to be very careful with that, therefore, I was not sure if I could give

you that copy or not. And since I was not sure, I told you that I would wait for you guys to talk to each other to determine whether I could give it to you or not.

Q Right. I think you indicated I needed permission -- or that you needed permission from Mr. Dunn's office to produce it to me?

A Right.

Q Now, at any time, Dr. Barbuto, did you have a release signed by Mr. Sorensen that would allow you to talk with anyone other than Mr. Sorensen or his representatives?

A I believe we had this -- we had all of those things when they come, the -- whatever that is.

Q I've seen some releases, but I didn't see anything that would release information to Dunn & Dunn.

A They -- I think they said they subpoenaed me to testify at trial and talk with them -- yes, that was back in May.

Q But was -- are you referring only to the subpoena to appear at trial?

A Well, my understanding was that will -- that allows me to talk to him, that's my understanding. You know, whether it actually says you can have a meeting or not, I don't know about that. But my understanding

was I was told that I was going to -- the court was defining that I should participate in this and that, therefore, I can talk with them.

Q Is that what Dunn & Dunn indicated to you or is that something you assumed on your own?

A Well, other times when we've had these -- we've had these, you know, subpoenas, they basically mean that I am now expected to talk with people involved in the situation, and it then means that the situation's outside of the normal, you know, patient confidentiality stuff because it's now a legal proceeding and I'm involved in that, so, therefore, I'm to talk to the involved people, so that's my understanding.

Q Now, the first subpoena I found in your record had you to appear on June 5th. Now, you had communicated through correspondence otherwise regarding Ms. Hanson's request and then furthermore in August and in September. Are you familiar with the *HIPPA law?

A Yes.

Q Do you find anywhere in your file a HIPPA release that was signed by Mr. Sorensen or his legal representative? I have not seen it, but I would love to see if you might have it and I just haven't seen it.

A Well, I'm not seeing something that says

specifically the HIPPA thing. I am seeing the subpoena to testify at trial, which as I'm understanding, once you get into that, you're outside the HIPPA situation anyway. It's not -- because you're now in a trial situation and consequently -- as I understand it, that takes you outside of that.

Q Even for ex parte contacts with opposing counsel with no notice given to plaintiffs?

A I don't know the nuances of your rules. My understanding of it is that when we are involved in legal work, when somebody says to us that you are involve in this, that that's now outside of the HIPPA restrictions. In other words, you don't go to the patient and say, Can I talk to this person? That isn't the way it works as I understand it.

Q Is it your understanding, then, that if a member of the media came and asked you about Mr. Sorensen that once receiving a subpoena that you could talk to the media about his personal life?

A Well, I think the media is much different. The legal world involves us, just as you guys have, in these proceedings and it's my understanding that when we are involved in this, when we are demanded to participate in it or asked to participate in it and we have been, you know, duly asked to participate in it,

that that's not in the legal -- that's not the HIPPA -- it's not in the HIPPA realm, it's outside of HIPPA which has to do with normal patient care and that sort of thing.

Now, if you go to the media, the media is not a legal entity and it's not a legal -- it's not the lawyers and the legal setting, so it's a different situation as far as I understand it.

Q And as far as you understand that you can talk once a subpoena has been issued, you can talk -- do you know what ex parte means?

A No.

Q Ex parte means that you can talk with someone without giving anyone else that's interested notice or knowledge that this conversation is taking place.

A Okay. I don't know about that. I mean that's your --

Q Is it your understanding, then, that once a subpoena has been issued to testify at trial, such as here, that you appear and give testimony on June 5th, that that would give you a carte blanche justification to talk with opposing counsel about your patient with no notice given at all to your patient?

A Yes, that's my understanding.

Q Have you done this before in the past where

you have gone ahead and had ex parte communications, as I've defined ex parte, with defense counsel when you have had patients either treating -- well, I guess it would have to be in a treating situation?

A Well, there are certainly patients where we get -- I mean, I see patients in my practice where we get involved in some aspect like this, you have a legal confrontation and it has to do with that patient. We get subpoenas for records all the time, that's almost a daily thing. So as I'm understanding it, when you have -- when you guys in the legal community define that we have to give this stuff, then that's -- we are supposed to do that. I'm not aware that there are some sort of nuances where you can do it this way but not that way. I'm not aware of that.

So in patients who have been clinical patients, there have been times when I have been asked by attorneys or somebody to talk about the patient as part of a legal process. As I understand it --

Q Even if it's the opposed attorneys?

A As I understand it, when you guys do your legal work and you put these issues at issue in the legal arena, you then, by that process, take the patient's privacy issue out of the privacy issue. In other words, you are now saying this is a discussion

which will take place in court and it is a discussion or in the legal arena and information now goes outside of the normal doctor-patient relationship.

So my understanding of it is that when you guys get involved and do this, it now no longer is restrained in the normal doctor-patient relationship and normal, you know, communication limitations. And as I understand it, it just -- just the patient's choice to be involved in the legal process and to do this is what basically then opens them up for this. In other words, the patient chooses to make this a social issue where information is being -- going to be handled by legal authorities, courts, attorneys, other kinds of things. And as I understand it, when the patient does that, they, then, have basically defined that they're allowing their information to be processed by this system and it is not -- it is not in the normal patient confidentiality realm any longer.

Q Bu that's --

A And I think you do have to be -- in other words, when you have information like this, it's not something where that suddenly gives you the right to talk to everybody on the planet, but the involved people, I understand, you can talk to.

Q With no notice to your patient?

A Yes, that is my understanding, yes. That is correct.

Q Do you recall being involved in a case involving Balyura?

A Yes, that's the case that I've referenced that was so ugly.

Q Where you were involved on behalf of the patient and then had an ex parte discussion with defense counsel, Joe Joyce.

A I recall that case very well and very unfortunately, yes. You know the details of that one.

Q And do you recall being -- meeting with Piero Ruffinengo?

A Yes.

Q And that -- did you not understand after that that it is inappropriate to talk to opposing counsel without proper notice?

A No, I didn't understand that. What I understood was this: First of all, as I understood the case with that particular case, as you know, this was a very unpleasant and very unfortunate situation. It was basically the situation where my brother-in-law, Joe Steele had asked me to see this patient, but then asked me to treat the patient and become a treating doctor, not an expert, but rather a treating doctor. So as I

understood it, I was a treating doctor not Joe's expert, and as I understood that, when Mr. Joyce became involved as the other attorney and told me that as the other attorney he had right to the information and right to talk to me --

Q Without notice?

A Of the patient?

Q To the patient, without notice to the patient, he had a right to talk to you?

A Yes, that was my understanding, is that he had a right -- because of your legal arena, that he had a right to talk to me about this patient because it was a legal confrontation and he was involved in it, and so when he came and actually was talking about another case where I was seeing the -- for which I was an expert in that case, he said, you know, Can I talk with you about this case? And I said, Well, is that appropriate, are you the attorney involved and is that appropriate to do that? And as I understand, he said yes, he told me that that was appropriate and I could talk with him.

So my understanding was in that situation that this was a discussion of being involved with attorneys who are trying to work out the case and who -- and because it's a legal arena, you can talk with them.

Now, the -- that particular case, I think Joe felt that I was his expert, I think was the issue, but the trouble is he didn't define it as such and I had actually been treating the patient.

So as far as I knew, I could not wear both hats, I could not be treating patient at the time -- actively treating the patient and at the same time wear the other hat. So as I understood it, that at that time, you know, I wasn't -- I was the treating doctor and this attorney was involved in the case and the case was before the courts, and consequently because it was before the courts, I was allowed to talk with the involved people and so, therefore, I was doing that, that was my understanding of how it worked.

MR. HUMPHERYS: I have no further questions.

MR. ALDERMAN: I just have one quick follow-up question.

EXAMINATION

BY MR. ALDERMAN:

Q Mr. Humpherys stated earlier -- and I believe he was trying to -- or he was quoting from your meeting that you had with him last Thursday, and he said that you had told him that you needed permission from Dunn & Dunn to give him this report dated 8/11/03. Do you remember that testimony?

A Yes.

Q Did anyone from Dunn & Dunn tell you that you needed permission to give that report to Mr. Humpherys?

A No, I am simply trying to be sure that what I am doing is appropriate because of that Balyura case. That was a very, very ugly situation and, you know, I'm trying to ever avoid having that kind of thing repeated. So consequently, I'm trying to determine what are your rules and how do we participate with these rules and, therefore, since I was not sure what the rules were and how it could be done, I said I needed to find out from you guys or have the two of you talk so that I could know what was appropriate to do.

MR. ALDERMAN: I have no further questions.

THE WITNESS: Can I ask a question?

MR. HUMPHERYS: We can go off the record.

(Deposition concluded at 5:42 p.m.)

-oo0oo-

(Right to read and sign above deposition not reserved by deponent or attorney as required under new Rules of Civil Procedure for cases filed after November 1999.)

John P. Barbuto, MD, PC
8074 South 1300 East
Sandy, UT 84094
Tax ID: 87-0616622

DATE
9/30/2003

TO:

Dunn & Dunn
Midtown Plaza, Suite 460
230 South 500 East
Salt Lake City, UT 84102
Attn: Kay Hanson, CLAS

AMOUNT DUE
$787.50

SERVICES RENDERED

DATE	SERVICE	CODE	AMOUNT	BALANCE
12/31/2002	**Balance forward**			0.00
	Sorensen, Nicholas-			
08/12/2003	**IME Services: records review with discussion but no current report (by request).**	99456	1,653.75	1,653.75
09/16/2003	**IME Services: metting with Mr. Alderman re evaluation of the patient.**	99456	787.50	2,441.25
09/23/2003	**PMT #4179223**		-1,653.75	787.50
09/23/2003	**Subpoena fee**	99456	18.50	806.00
09/23/2003	**PMT #04700**		-18.50	787.50

EXHIBIT 4

To ensure proper credit, please indicate the NAME of the IME PATIENT on the payment. Thank You. (Proper credit is not easily determined from case name, insured name, or other reference.)

TOTAL
$787.50